



Office Of The Controller

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COUNTY CONTROLLER

DEPUTY CONTROLLER

The Cost of Misdiagnosis

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This is a Viewpoint paper and as such the information in this document originates from the office of the Lehigh County Controller and does not represent an audit performed under the Generally Accepted Government Auditing Standards (GAGAS).

NOTE

This report was assembled and analyzed by the Controller's Office, focusing on costs incurred by the county based on the potential misdiagnosis of child abuse. While the Controller's Office has reviewed various spending associated with Children and Youth Services (CYS) costs, we cannot access specific cases or medical records. Consequently, we cannot assert the cost of misdiagnosis in a particular case. Instead, this report draws on national averages and publicly available information to estimate those. While it is impossible to nail down the specific costs incurred by the county at this time, the fact that there are costs to the county through foster care, litigation expenses, and many other costs is beyond reasoned dispute.

This audit initially began as an investigation into the costs associated with the potential misdiagnosis of Munchausen Syndrome by Proxy. However, it quickly became apparent that the inquiry needed to include other areas, such as shaken baby syndrome, various forms of head trauma, and other rare diseases frequently misclassified as child abuse. Moreover, the reader must understand that our investigation did not reveal a few anomalies attributable to human error. Instead, our analysis showed statistical anomalies suggesting a pattern that requires further investigation.

To that end, the Controller's Office is referring this matter to the Auditor General's Office of Pennsylvania, which possesses the authority to review case records to investigate this matter. Concomitantly with that referral, my office will submit a request to local hospitals to participate and have an independent third party review medical records.

Please note: Nothing in this document will preclude the Controller's Office from conducting further audits to the Lehigh County Department of Human Services in compliance with the Generally Accepted Government Auditing Standards (GAGAS), also known as the Yellow Book standards

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Executive Summary

An analysis uncovered alarming statistics that the Northeast region of Pennsylvania diagnoses 40% of the state's Munchausen syndrome by proxy cases (MSBP) (used to signify medical child abuse(MCA)), despite having just 11% of the under-18 population. This disproportionate rate points to potential systemic overdiagnosis of this rare disorder.

Once accused of child abuse MSBP or other types, the process offers little recourse for parents to defend themselves. An "indicated" finding based on minimal evidence instantly labels caregivers as child abusers without any trial or a chance to defend themselves. This can cause an individual to lose their job or make it more difficult to find employment. It is only much later, when parents are able to present evidence to a judge, that 90% of these independent appeals boards reject these findings. This means the "indicated" status is removed 90% of the time.

To give you an idea of the scale, consider Lehigh County. Between 2016 and 2021, over 886 people were added to the Pennsylvania child abuse registry. Childline listed these families without giving them a chance to present their side of the story and without a judge or a jury involved. Now, if all of these families had the resources—time, energy, and money—to challenge the accusations based on the current 90% overturn rate, this could mean that Childline wrongly labeled 797 caregivers as child abusers.

This controller report emphasizes the need for systemic reforms. If there is a misdiagnosis, it can inflict a financial burden on the taxpayers of Lehigh County. These costs include casework, foster care, kinship care, solicitors, parental programs, defending lawsuits, and more. It is crucial to address these concerns to ensure the efficient allocation of resources.

The facts uncovered warrant immediate action locally and statewide. There are many recommendations in the report. The top three include:

1. Lehigh County should require a second opinion concerning the diagnosis of medical child abuse when considering removing children from their families. This second opinion should meet the following criteria:
 - It should be from a medical professional affiliated with a different hospital network or CPU than the one involved in the initial diagnosis.
 - The individual providing the second opinion must have experience or expertise in the specific specialty that is relevant to the case in question.
 - This procedure should be vetted by an independent third party specializing in these issues.
2. The county should hire an independent investigator to provide an unbiased review of the processes before and after a caregiver is "indicated." The selection of the investigator should be

undertaken in partnership with SEIU (Service Employees International Union). This collaboration aims to foster a sense of inclusion among employees, ensuring that they are integral to the process and reinforcing their confidence that they will not be unfairly targeted.

3. The county should request that hospitals also conduct an independent review of the Medical Child Abuse cases over the past 5 years.

Background

THE CATALYST

On June 2nd, 2023, an unexpected video surfaced that sparked the interest of the Lehigh County Controller. An attorney with a history in child advocacy, posted the video. The content suggested a legal case in Allentown, although it did not provide specific information. “Children and youth” were referenced. Considering the geographical context, the controller assumed that the events likely occurred in Lehigh County.

To uncover more information, the controller reached out to The Parents’ Medical Rights Group (pmrglv.com). The organization’s mission is “To support parents in the development, education, and expression of their parental rights.”

CLARIFYING CALL WITH PARENT’S MEDICAL RIGHTS GROUP

The Parent’s Medical Rights Group (PMRG) coordinated a conference call responding to the controller’s request. The family asked the controller to review the costs involved in any misdiagnosis. They explained their story to the controller and identified where they believed the county might incur unwarranted financial charges.

During the call, the group recounted a distressing experience involving a family whose son had a complex, previously diagnosed medical history. The son, who we’ll refer to as Orion, was taken to the emergency room and admitted to a local hospital due to his deteriorating health.

During Orion’s stay at the hospital, he alleged abuse by his parents. As noted in his records, this allegation was partly a function of his illness and partly due to his frustrations at home. The hospital staff nurses are mandated reporters. If there is an allegation of child abuse, they must report it.

The ER Doctor informed the parents that Orion’s use of the word “abuse” required them to make a report through ChildLine, the state’s centralized child abuse hotline. An excerpt of the referral factors recounting Orion’s claims and the doctors’s interpretation follows here:

REFERRAL FACTORS	
TYPE OF MALTREATMENT	ORION Parent names removed
Victim, [redacted], claims that parents [redacted] are mentally abusing him calling him useless because of his medical issues and does not want to be at home with them	
CHILD FUNCTIONING	[redacted] appeared to be in a good mood, appears to be tired of parents discipline towards him
ADULT FUNCTIONING	Unknown

Figure 1: Referral factors

Before the parents returned the next morning (according to the parents) without consulting the parents or Orion’s previous doctors, a physician at the hospital evaluated Orion. This evaluation resulted in the hospital holding Orion and ultimately led to the diagnosis of Munchausen syndrome by proxy (MSBP).

MSBP is a type of child abuse where a caregiver intentionally falsifies or induces a disease or illness in a child. Often, this caregiver adopts the role of a concerned and anxious parent. In cases of MSBP, the caregiver, usually the mother, inflicts injury on the child, either by convincing them they are sick when they are not or making them sick.

When the parents returned to the hospital to visit their son the next day, the staff ordered them to leave and denied the parents information concerning their son’s whereabouts. This series of events caused the controller to further investigate the potential fiscal implications for the county.

367 DAYS OF GOVERNMENT CONTROL

This parent recounted the story as follows:

Seeking emergency care for their son’s previously diagnosed illness launched the parents into a nightmare. For 367 days, the parents were forced to navigate a complex system while striving to prove their innocence and regain custody of their son. The following text is the description of events as the parents provided. Some keywords are necessary for the reader to help understand the timeline.

Terms to help understand the timeline can be found in the Glossary at the end of the report.

Day 0 (05/20/22): Orion, age 16, was taken to the ER by his parents due to deteriorating health. Orion had several medically complex issues that have been treated for years. During Orion’s examination, he alleged emotional abuse (see 1). Due to mandatory reporting, the hospital placed the first call to ChildLine, categorizing it as general protective services.

Orion’s long-term treating metabolic geneticist, rheumatologist, and pediatric neurologist phoned

into the emergency room to consult with physicians. The long-term treating physicians provided recommendations for medical treatment, and the ER doctors began this treatment.

The parents were in a separate room, and hours after arriving at the ER, the parents were told Orion was resting comfortably and told it was best for the parents to go home. The parents left the hospital with plans to return in the morning.

Day 1 (05/21/22): The parents arrived at the hospital the following day to see Orion; however, the front desk and security told them they could not enter. The hospital had banned the parents and made Orion a “do not announce” patient. This action also barred the parents from receiving any medical information, the location of their child, or confirmation that he was still there.

The parents returned home without any information and called their child’s treating physicians, asking them if they had any information on their son. A metabolic geneticist from Cleveland Clinic spoke with a member of the treating hospital’s Child Protective Unit (CPU) to discuss Orion’s medical history and diagnoses- including objective testing that rejected the MSBP diagnosis. The metabolic geneticist immediately followed up his phone call with an email rejecting the notion that there were any fabricated symptoms or overmedicalization on the part of the parents.

The hospital suspected MCA. It believed that there were no underlying medical problems with Orion but that his parents were convincing him that he was sick. One way to prove this is to remove the child from all his current medications and monitor the results.

On this day, the “Demedicalization” process began by the CPU without Orion’s parents’ knowledge or consent. This is the process of stopping or withdrawing all medical treatments from a patient to evaluate their untreated symptoms and baseline condition. The goal is to determine if the illness persists without medical interventions.

Day 2 (05/22/22): In 30 hours, without speaking with or meeting the parents, doctors with the CPU finalized a 22- page report concluding that Orion was a victim of MSBP. This report concluded that (a) the parents fabricated all of Orion’s medical conditions, (b) he should not return home, (c) he should have no contact with his parents, and (d) his younger brother, Yonas (the younger child, age 13, who was later involved in the case—whose name is also a pseudonym), should be removed from the home as well.

The same day, the hospital made a second ChildLine report, lodging additional allegations of MCA against the parents. A Lehigh County children and youth services (CYS) intake worker visited Orion in the hospital, reported that she had “nothing to take before a judge,” and told Orion that he should return home. The intake worker called the parents and notified them of her conclusions regarding their son and that she questioned a doctor who told her she was “demedicalizing” Orion. The intake worker notified the child protection doctor that “Orion’s parents still have custody.” However, demedicalization continued without parental consent.

Day 3 (05/23/22): A caseworker from CYS visited the parents' residence. The parents provided releases for CYS to speak to teachers, doctors, and therapists. Interviewed Yonas alone, who expressed no concerns about his parents, home, or medication conditions.

Day 7 (05/27/22): CYS filed a motion for emergency custody for both Orion and Yonas.

Day 11 (05/31/22): The hospital discharged Orion directly into foster care.

Day 17 (06/06/22): A shelter care hearing occurred. The hearing concluded within five minutes, with no opportunity for the parents to present evidence.

The judge ordered kinship care for Yonas and foster care for Orion. Yonas transitioned from the home to kinship care on this day. Parents no longer had physical, legal, or medical rights to either son.

Day 19 (06/08/22): Yonas was admitted to the hospital so its CPU could "demedicalize" him. The goal was to remove Yonas from medication and treatments to "see what would happen." Without speaking to Yonas' parents or with his treating providers, he was diagnosed as being a victim of MSBP and a report was generated that Yonas should (i) not have contact with his parents, (ii) remain in foster care, and (iii) his home was not safe or nurturing.

Day 24 (06/13/22): Yonas returned to Kinship care. Yonas' medical symptoms worsened, rendering it difficult for him to speak, eat, do school work.

Day 38 (06/27/22): The parents welcomed Yonas back to their home per the court-approved agreement between both parties, albeit in deteriorated health. The parents had legal and physical custody but did not have medical rights. In-home service provider programs began. This refers to a professional service provider who may visit the family's home to offer support, education, and assistance as required by CYS. Depending on the specific needs identified by the CYS, this person or team could offer a range of services, including counseling, parent coaching, crisis intervention, and more. (Controller's note: All of these services are paid for by the taxpayers.) Their goal is to promote a safe and nurturing environment within the home.

CYS took Yonas back to the hospital physician, who acknowledged Yonas' worsening medical symptoms and prescribed a rescue medication, bloodwork labs, and an ongoing medication delivered by injection. This medication was a stronger medication (with more significant side effects) than he was previously prescribed prior to demedicalization. His parents were not allowed to attend his medical appointments.

Day 68 (07/27/22): CYS filed a petition to remove Yonas from his home for a second time, citing his worsening medical condition in his parents' care despite Yonas's worsening in kinship care before returning home to his parents.

On the same day, authorities issued the first indication letter for MCA pertaining to Orion. His parents did not get a chance to be interviewed. They also received an unfounded letter for Yonas (this means that CYS could find no indication that the parents were abusing Yonas).

Day 73 (08/01/22): The judge rejected CYS's second attempt to separate Yonas from his parents and restored all parental rights to Yonas.

On the first day of the trial (which was a half day), the only evidence presented was the testimony of a CPU doctor, with no time for cross-examination. The Court then scheduled the next two trial days (non-consecutive).

Day 168 (11/04/22): The CPU doctor was cross-examined by the defense.

Day 185 (11/21/22): Orion and Yonas' long-term treating pediatric neurologist testified for a full day substantiating both boys' conditions and rejected the notion that their parents overmedicalized them or fabricated or fictionalized prior statements.

A second ChildLine report, psychological abuse, was made based on the conclusions of a psychologist's report of Orion. The psychologist's only investigation included conducting a one-time evaluation of Orion and reviewing some of the hospital records generated by the CPU. The doctor did not review the child's primary care or treating expert's physician records, speak with the parents, contact the foster mother, contact teachers, or any other person who knew Orion prior to CYS removal. Yet, the doctor concluded he suffered psychological abuse.

Day 230 (01/05/23): A second indication letter for Orion arrived, based on the psychologist's report. No interview with the parents was conducted.

Day 272 (02/16/23 & 2/17/23): The Court held two successive trial days.

Day 367 (05/22/23): The Court had scheduled a full week of trial days. At the beginning of the Monday morning trial session, after 367 days, CYS **withdrew** its case against Orion's parents.

CAREGIVERS RECOUNTING THEIR STORIES

Along with the case summarized from above, there are additional instances to consider. The cases that follow come from the perspectives of the caregivers. This information is a summary of the facts as provided by the caregivers who conveyed it.

Case: 1

County Residence: Lehigh County

Number of Children: 2

Issue: Disregarded diagnoses from multiple specialists

After taking their oldest son to a local hospital due to a medical crisis, within hours, a doctor with the CPU and one of their assistants accused both parents of having MSBP, despite neither of them having met either parent. The parents were banned from the hospital and refused any medical information about their son. The hospital eventually told the parents that their child's prior diagnoses were invalid.

These diagnoses came from expert specialists at renowned institutions. They were never permitted to contact their son after the day they took him to the ER. After spending a week in the hospital, Lehigh County CYS obtained an emergency order for custody of both parents' children. The older child remained in the hospital for 11 days, and the younger child stayed there for five days. During their hospitalizations, the hospital terminated their regular medication at the CPU's doctor's direction.

The hospital discharged each child to a placement home. The oldest child entered foster care, and the youngest entered kinship care. Hospital physicians controlled all of the older child's medical care. Both children suffered setbacks while outside their parents' care. Although specialists at prestigious institutions (e.g., Cleveland Clinic) disagreed with allegations made by the CPU, the county continued to pursue this case for an entire year. **Finally, halfway through the trial, the county withdrew its petition without conditions.**

Case: 2**County Residence: Northampton County****Number of Children: 2****Issue: Disregarded diagnoses from multiple specialists**

A caseworker visited their home concerned about the youngest child's truancy issues. The mother informed the caseworker that the Children's Hospital of Philadelphia (CHOP) diagnosed the child with a medically complex condition. The caseworker told the mother that she needed to take the girl to a local hospital's CPU so its doctors could confirm the diagnoses from CHOP specialists. Then the caseworker would close the case. The mother and father complied. The center immediately separated the parents from their child and confined them to the lobby.

Within three hours, the caseworker returned with an emergency order taking custody of the girl and telling the parents that it was because the hospital decided the CHOP diagnosis was invalid and the mother had MSBP. The caseworker banned the parents from the hospital. The child remained in the hospital for five days and stopped all her current medication. The hospital subsequently discharged the child to foster care. Within a week, an emergency custody order compelled the removal of the parents' older child. The older daughter was hospitalized, removed from her medication, and treated by the hospital, claiming there was no basis for the CHOP diagnosis. The CPT doctor ordered that both children only be seen by the hospital's affiliated providers. The county's case against the parents ended with a dismissal nine months later. **The girls are now back home and on the same medications and treated by CHOP.**

Case: 3**County Residence: Lehigh County****Number of Children: 2****Issue: Disregarded diagnoses from multiple specialists**

Within two weeks of a procedure on a minor child, a case worker showed up at the parents' door

stating, “We have concerns.” The mother let the caseworkers in the home. The caseworker told the mother he had a document stating the child had 2,000 blood tests. The mother handed the caseworker a letter outlining the treatment protocol the family was to follow for their medically complex son. The neurologist signed the protocol and included his phone number should anyone have questions. The caseworker stepped out of the home to call his supervisor. He re-entered the house, stating that he had a court order to remove the child, and handed the order to the mother. The caseworker took the child to a local hospital, where they discontinued his medication and treatments. The hospital restricted the child’s care to its own affiliated providers and banned the parents from the hospital after concluding that the parents had MSBP and were medically abusing their son. **Despite the child’s treating specialists disagreeing with the hospital’s allegations, they remained separated from their son, and the case continued for nine months until the county withdrew.**

Case: 4**County Residence: Montgomery County****Number of Children: 3****Issue: Rare Diseases Misdiagnosed for Physical Abuse**

A mother took her toddler to a local hospital ER for fussiness and restricted movement. X-rays revealed a lumbar fracture and multiple other fractures in different stages of healing. Without ever meeting the father, the hospital’s CPU doctor told the mother that her husband was abusing the baby and that she needed to leave him and “never look back.” The mother, a nurse, questioned the doctor if there was a possible medical explanation due to a family history of fragility of bones. The doctor threatened the mother’s nursing licensure and told her she was lucky to have custody of her child. Due to the doctor’s allegations, the father was charged and incarcerated for three months. The mother was encouraged to divorce the father to show she was protecting her children and was repeatedly asked if a divorce went through. Eventually, the mother and father did divorce. **During that time, the mother took the child to CHOP, where genetic testing revealed that the child had osteogenesis imperfecta (“Brittle Bone” disease). Upon receiving the genetic report, law enforcement released the father from jail.**

Evidence of Systemic Issues in Abuse Diagnoses

The controller decided to look at this issue because of the costs involved. This decision sparked further research into the potential economic burden resulting from misdiagnosis, with a particular focus on the causes and effects within Lehigh County. This inquiry revealed that the costs include liability, investigation (caseworker time), the additional services provided, foster and kinship care, legal system costs, and the opportunity costs borne by families in greater need and other expenses. Taxpayers pay for all these costs.

THE BASICS OF MUNCHAUSEN SYNDROME BY PROXY

To frame the investigation, the controller aimed to explore whether this was a one-time instance or was systemic and what the costs to the county are when a misdiagnosis occurs.

Munchausen syndrome by proxy (MSBP) is a psychological disorder in which a caregiver deliberately fabricates or induces illness in someone under their care, usually a child, to gain attention or sympathy. The perpetrator will exaggerate, fake, or cause disease-like symptoms in the victim, subjecting them to unnecessary tests, treatments, and surgeries. They will misrepresent the victim's condition to medical professionals and others, often by falsifying medical records, histories, and tests.

The motivation is a psychological need for the **caregiver** to be a heroic, self-sacrificing caregiver. They seek the sympathy and attention that comes with having a sick child. The disorder is considered a form of child abuse. Victims are often infants or toddlers, but MSBP abuse can occur to children of all ages, older people, and differently-abled adults.

Since MSBP is an infrequent condition, it presented a unique opportunity for statistical analysis. The controller's office began by reviewing reported cases of MSBP, a disorder known by several other names, including:

1. **Factitious disorder imposed on another (FDIA):** This term emphasizes the psychiatric nature of MSBP, highlighting that the caregiver is intentionally fabricating or inducing symptoms in another individual, typically a child. It underscores the underlying psychological motivations and the deceptive behavior exhibited by the caregiver (Abdurrachid and Gama Marques 2022).
2. **Caregiver-fabricated illness in a child:** This subtopic emphasizes the central role of the caregiver in fabricating or exaggerating symptoms in the child. It highlights the power dynamics at play, where the caregiver assumes control over the child's medical narrative, often seeking attention or validation for themselves through the child's illness (Flaherty, Macmillan, and Committee On Child Abuse And Neglect 2013).
3. **Pediatric condition falsification:** This term underscores the impact on the child, emphasizing that the caregiver is falsifying or exaggerating the child's medical condition. The particularly intricate topic of parental decision-making regarding a child's medical care points to complex concerns about the multiple ways in which an ill-advised choice could compromise a young life's blossoming, in body and mind alike, and how it might distort the course of treatment and maturation. (Kucuker, Demir, and Oral 2010).
4. **Medical child abuse (MCA):** This term highlights the abusive nature of MSBP, framing it as a form of child abuse perpetrated through the medical system. The repeated actions and behaviors of the caregiver exemplify a sinister deception amounting to a betrayal of trust and a malicious threat to the child's health and welfare, constituting a severe infringement of their fundamental rights and interests. (Hornor 2021).

5. **Fabricated or induced illness in children:** This subtopic focuses on the manifestations of MSBP in children, highlighting that the illness is either fabricated (nonexistent) or induced (caused deliberately) by the caregiver (Lobo 2020).
6. **Factitious disorder by proxy (FDBP):** This term encompasses the broader concept of MSBP, emphasizing the presence of a factitious disorder in the caregiver. The caregiver's behavior stems from a complex set of internal drives and incentives, frequently rooted in a longing for affection, compassion, or authority that manifests in paternalistic actions (Shaw et al. 2008).

The DSM-5, "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition," is the 2013 update to the American Psychiatric Association's classification and diagnostic tool. In the United States and many other countries, the DSM is the primary system used by clinicians for the diagnosis of **mental disorders**. The picture below is their explanation of the fictitious condition, one of the many names for MSBP.

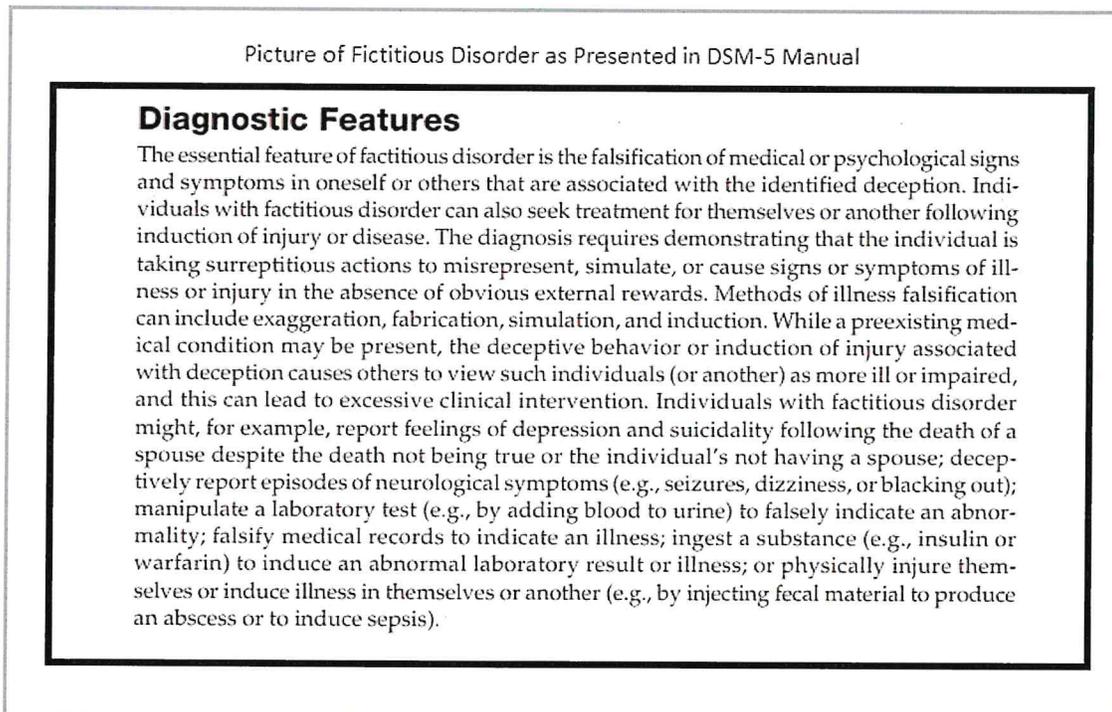


Figure 2: DSM-5 Entry for Fictitious Disorder

Prevalence of MCA

The journey to determine the presence of a systematic issue started with compiling data from the Child Abuse Reports, provided by the Pennsylvania Department of Health and Human Services. This data source provided a comprehensive overview of substantiated allegations, one of which included MSBP.

The prevalence of MSBP remains a subject of dispute. Advocates for thorough research studies argue that no solid studies prove a specific prevalence of MSBP. However, others point to research that suggests an annual rate of 0.4–0.5 per 100,000 children under 16 (or a rate of 0.0004–0.0005%), while other studies propose rates of 2.0–2.8 per 100,000 children under one year of age (or a rate of 0.002–0.0028%). Although the United States lacks research, research from other countries confirms this range of incidence (0.5-2.0 per 100,000 for those under 18).

For our benchmark of MSBP, the controller’s office chose to work within the most inclusive parameters provided by these studies. Therefore, we estimated the occurrence of MSBP to range between 0.5 to 2 children per 100,000 children. Our focus remained on evaluating the prevalence of the disease in Pennsylvania. This range was very generous. The controller could find no scientifically peer-reviewed studies with a large enough population to be as generous as this benchmark. The literature suggests that this is such a rare disease that no one doctor could diagnose it. It requires a team of doctors to diagnose it with multiple specialties, including psychology and rare medical disorders.

NORTHEAST REGION VS. SOUTHEAST REGION

With an MSBP benchmark in place, the controller’s office compared all of the regions in Pennsylvania but paid particular attention to the two highest regions: The Northeast region and the Southeast region, which has the next highest number of MSBP cases and includes Philadelphia. We considered the number of children, child abuse reports, serious mental injury reports, and MSBP cases.

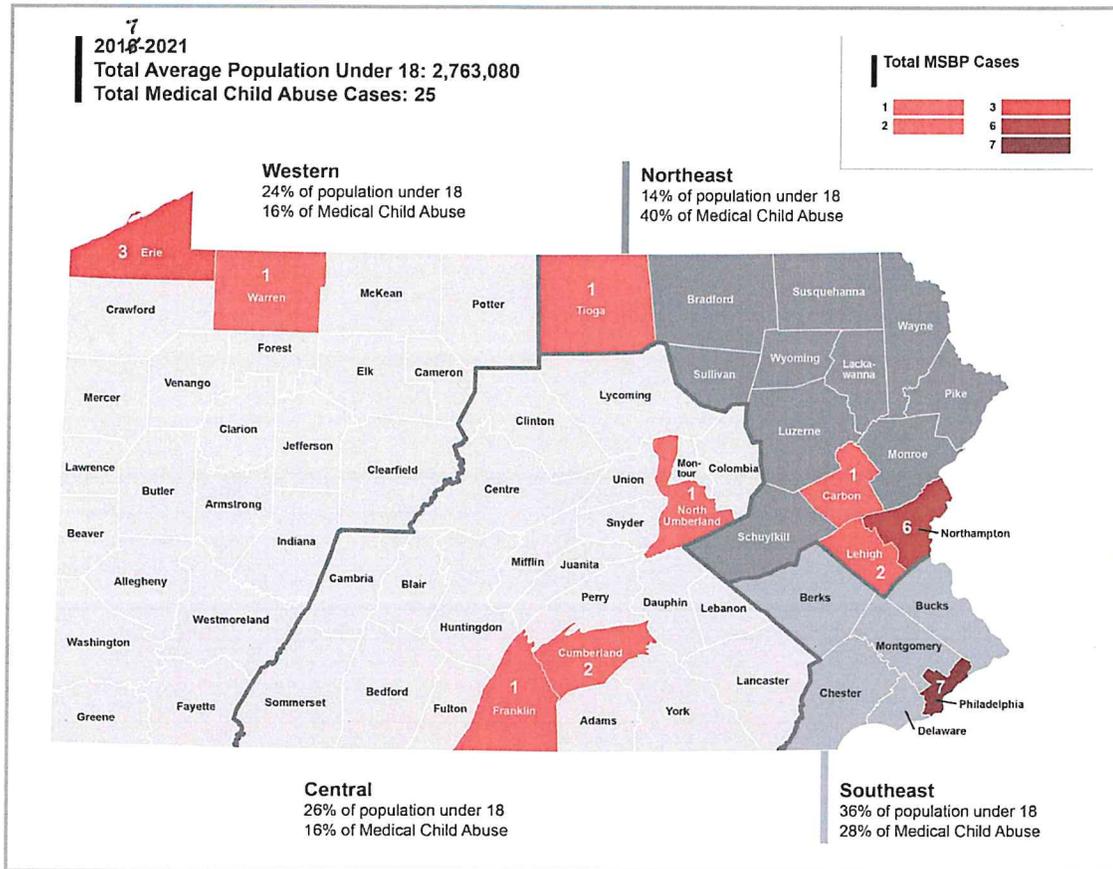


Figure 3: Regions

(“Regional Child Youth Map,” n.d.)

Our findings are shown in the following table:

Region	Average total number children per year since 2017-2021	Total child abuse reports between 2017-2021	Total Serious Mental Injury Reports 2017-2021	Total MSBP cases between 2017-2021	Total Substantiated/ total reports
Northeast	380,000 (14%)	32,000 (17%)	24 (14%)	10 (40%)	4413/32,398 (14%)

Region	Average total number children per year since 2017-2021	Total child abuse reports between 2017-2021	Total Serious Mental Injury Reports 2017-2021	Total MSBP cases between 2017-2021	Total Substantiated/ total reports
Southeast (Includes Philadelphia)	990,000 (37%)	54,000 (28%)	62 (36%)	7 (28%)	6893/54,008 (13%)

When comparing the top two regions regarding MSBP cases from 2017-2021, the Northeast region had a higher number of cases, with 10, compared to the 7 cases in the Southeast region. While this number does not appear to be that much larger, the Southeast has more than 2.5 times the population of the Northeast.

THE NORTHEAST REGION STANDS OUT

The Northeast’s elevated rate of MSBP, considering its smaller child population and fewer instances of child abuse and serious mental injuries, clearly indicates that something may be amiss. These statistics serve as solid evidence, leading the controller to believe these pressing issues require attention. The controller’s office sent the data collected by DHS to Scott Bailey, Ph.D., the Chair and Professor of Psychology at Texas Lutheran University, for a statistical review and a second opinion. The professor stated:

Given the seriousness of child abuse and the rarity of Munchausen Syndrome by Proxy, close examination into what is driving the high number of diagnoses in the Northeast region... appears not only merited but urgent.

The Controller believes that the higher prevalence of MSBP in this region underscores the gravity of the situation and **warrants additional investigation**. The Dr. Bailey statistical report is included in the appendix.

The Costs to the County

THE FINANCIAL IMPACT OF MISDIAGNOSIS

When child abuse is misdiagnosed, the county bears high costs for foster care, solicitors, guardian ad litem, community programs, and many other indirect costs. There are rare diseases that doctors may misdiagnose. Doctors may misdiagnose conditions like osteogenesis imperfecta or other rare diseases and instead presume some form of child abuse. When doctors misdiagnose conditions like osteogenesis imperfecta as child abuse, it quickly accumulates substantial costs and strains limited county resources. (Singh Kocher and Dichtel 2011)

Counties can reduce this heavy financial burden by having caseworkers require more than one diagnosis and getting a second opinion outside the same hospital network. The concern with using a doctor in the same hospital network is that “collegial bias may make physicians hesitant to counteract the opinions of the first physician” (Halasy and Shafrin 2021). Furthermore, if the child has already been diagnosed with another disease, a pediatrician should not be the only doctor involved in the diagnosis.

Maxine Eichner, Graham Kenan Distinguished Professor of Law, University of North Carolina School of Law; J.D., Ph.D. said:

Parents following one doctor’s medical opinion over another doctor’s medical opinion is NOT and never should be considered child abuse.

Economic Costs

The National Coalition for Kid Protection Reform estimates that supporting just one foster child costs \$25,000-\$30,000 annually. Legal fees associated with wrongful removals, including judges, attorneys, clerks, and security, may cost up to \$20,000-\$25,000, over and above the costs of foster care, for each affected child. Additional expenses come from counseling, in-home services, and children’s community programs provided through the county (“Monarch Family Services Kinship Programs - Monarch Family Services” 2023).

Misdiagnosis raises economic costs beyond the direct program and legal expenses through unnecessary medical procedures and treatments, potential legal action, and eroded trust in the healthcare system. Children incorrectly diagnosed with abuse may undergo invasive, expensive, and even dangerous testing and surgeries. These unnecessary procedures increase medical expenditures, lengthen hospital stays, and often require further treatment (Tsai and Jao 2020).

When a misdiagnosis occurs within the county’s social services system, the consequences can be wide-ranging and multifaceted. One of the most immediate impacts is the allocation of caseworker time.

A misdiagnosis necessitates that caseworkers dedicate valuable hours to cases that may not require their level of intervention. This misdiagnosis diverts resources from children and families that might need help. This misplaced focus can lead to the provision of additional services that are inappropriate for the child's actual needs. Whether it's unnecessary foster care placement or misguided counseling services, these additional interventions add financial strain to the county's budget and, more critically, may fail to support the child properly.

Lehigh County spends around \$8M annually on foster care and kinship care services. It is vital to have the proper resources allocated for those children that need it. When a misdiagnosis occurs, the county allocates monies for that child. This spending can cause the county to spend more than is necessary. The County also spends more than \$2M on Counseling services. These are services that the children or the parents may utilize. Once again, these kinds of programs may not be necessary and waste taxpayer money.

In managing these complex situations, there's a significant overhead placed on management and administrative staff. Management Overhead includes coordinating services, overseeing interventions, and possibly managing the fallout from a misdiagnosis. The time and resources spent on these tasks could be used more efficiently elsewhere, often leading to lost productivity in other areas. Other essential services may suffer from delays or reduced quality as attention and resources shift to address the misdiagnosed cases. Over time, this lost productivity can create backlogs and strain other parts of the system, possibly reducing overall efficacy and community trust in the services provided. The cumulative effect of these missteps forms a complex challenge that can affect the immediate well-being of the children and families involved and the broader operational efficiency and effectiveness of the county's social service system.

Litigation Costs

Legal action stemming from misdiagnoses could also impose significant costs through damages and legal fees if families pursue claims of wrongful injury. Settlements will drain county resources already stretched thin. In addition, frequent misdiagnoses damage public faith in the county's CYS. Rebuilding such trust requires substantial effort and resources.

The potential for litigation based on child abuse misdiagnoses places further financial strain on county governments. In one example, a lawsuit filed against Johns Hopkins Hospital by the parents of a child mistakenly diagnosed sought more than \$200 million in damages (DailyMail.Com 2023). The Florida Department of Child and Families is a party to that lawsuit. Two other defendants in that case settled for \$2.5M (Evans 2023). The significant legal expenditures, including legal fees, court costs, and potential settlements or verdicts, quickly accumulate and impact the county's budget and resources.

As evident from a statement by Johns Hopkins Hospital, hospitals at times try to shift the responsibil-

ity back onto the county/caseworkers.

“Our first responsibility is always to the child brought to us for care, and we are legally obligated to notify the Department of Children and Families (DCF) when we detect signs of possible abuse or neglect. It is DCF that investigates the situation and **makes the ultimate decision** about what course of action is in the best interest of the child.” (emphasis added) (Etienne and Roedel 2023)

A quick search on the internet will give you an idea of the possible exposure the county could face. The ten largest medical malpractice verdicts in 2022 range between \$18M and \$111M in damages (“Ten of the Largest Medical Malpractice Verdicts of 2022,” n.d.). These don’t include any cases settled out of court where awards could have been more but were not recorded. Improving diagnostic accuracy through increased provider training and education, rigorous quality control methods, thorough examinations, team-based approaches, and advanced diagnostic tools could reduce these high costs.

Even though the county and its employees enjoy immunity that immunity may potentially be breached by overreliance on a single doctor. In a case out of NY several people were sued including a caseworker and commissioner. Both individuals believed they had qualified immunity. Dora L. Irizarry, United States District Judge said:

In this case, the allegations in the complaint and other cases of which the court has taken judicial notice in this opinion make it plausible to believe that [the agency] followed a custom of relying on the child abuse diagnoses by [The Doctor], when such reliance may have been unwarranted and may have contributed to the violations of plaintiffs’ constitutional rights in this case and others.

Furthermore, it is plausible that Commissioner [xxxxx] may have been or should have been aware of this custom, given the apparent frequency with which the agency has relied on [The Doctor] opinions, both prior to the initiation of and during Family Court proceedings and the severity of the consequences that has resulted from such reliance. Therefore, the court declines to dismiss the claims against Commissioner [xxxxx] at this junction of the litigation.”

Lawsuits stemming from overreliance on a single doctor’s diagnosis or opinion may expose counties to legal liabilities. While the examples specifically mention medical malpractice, the underlying issues of overreliance may extend to other areas, such as interference with familial relations. If a county’s actions contribute to unlawful practices or violations of an individual’s rights, the county may be held financially responsible. This could lead to the county allocating funds to cover legal settlements or judgments, highlighting the importance of second opinions. In addition to the immediate monetary costs, the threat of legal action arising from incorrect child abuse diagnoses can have lasting detrimental effects on a county’s financial health and economic development. Lawsuits damage its reputation, discouraging businesses from locating in the area and hindering growth.

Counties should train caseworkers on diseases that mimic child abuse to mitigate litigation risks and expenses. This medical condition training will enable caseworkers to properly evaluate diagnoses instead of just accepting one doctor’s preliminary conclusions. The goal should not be to become a doctor or question every doctor’s diagnosis. The goal should be comprehensive training, clear protocols, and effective oversight. This training will give a caseworker a broader picture and ensure that child abuse conclusions have solid evidence before they initiate legal action.

Misdiagnosis also put a strain on county resources in the form of increased custody litigation. In situations where a child’s parents are separated and one or both parents are wrongfully accused of child abuse, the result is often protracted litigation, burdening our judges, their support staff and our clerk’s office, all of which are paid for by the taxpayers.

ENSURING EVERY DOLLAR COUNTS

The Office of Children and Youth Services (OCYS) of Lehigh County operates with an annual allocation of more than **\$30 million**. This funding aims to assist and protect our children and families from abuse. Nearly 77% of its financing originates from external sources, such as state, federal, or other grants. County residents directly fund the remaining 23%, nearly \$8 million, through property taxes.

Regardless of the funding source, the controller maintains that all funds should receive equal care and attention, akin to the dedicated handling of the property tax dollars from Lehigh County residents.

Categorizing these costs into distinct categories or “buckets,” as illustrated in the table below, helps in understanding the allocation of these funds.

In-Home Services	Community-Based Placement	Institutional Placement
Adoption Service	Alternative Treatment	Juvenile Detention Service
Adoption Assistance	Community Residential	Residential Service
Subsidized Permanent Legal Custodianship	Emergency Shelter	Secure Residential Service (Except YDC)
Counseling	Foster Family	YDC Secure
Day Care	Kinship care	Administration
Day Treatment	Supervised Independent Living	
Homemaker Service		
Intake and Referral		
Life Skills		

In-Home Services	Community-Based Placement	Institutional Placement
Protective Service - Child Abuse		
Protective Service - General Service Planning		
Juvenile Act Proceedings		

Each of these categories corresponds to a service that the agency provides. For example, the “In-Home Services” category covers essential services such as adoption assistance, daycare, counseling, and services to protect children from abuse. The “Community-Based Placement” category includes services related to foster families, alternative treatments, and kinship care. Lastly, the “Institutional Placement” category includes services like juvenile detention and residential services.

Building Cases

THE CASEWORKER’S ROLES

Caregivers that have been reported of child abuse are assigned a case worker. Caseworkers for children and youth services agencies have the role of protecting children from abuse and neglect. Their primary duties include:

- Investigating reports of maltreatment
- Assessing risks to children
- Creating case plans for families
- Monitoring child welfare cases
- Facilitating out-of-home placements when necessary
- Working towards safe family reunification or alternative permanent placement
- Representing the agency in court
- Coordinating between various providers
- Maintaining detailed case records

Through home visits, interviews, evaluations, service referrals, legal interventions, and constant vigilance, a caseworker’s goal is to defend vulnerable children while supporting families to create stable, loving homes whenever it is possible and safe. Dedicated caseworkers, unfortunately, bear the brunt when doctors misdiagnose child abuse. The caseworkers must build abuse cases against parents

wrongfully accused of MCA. These complex investigations require caseworkers to collect all medical records, contact people familiar with the children, and document details. This process drains county resources.

“A power imbalance between child-welfare caseworkers and child-abuse pediatricians makes it difficult for caseworkers to question the doctors. An entry-level caseworker job typically requires just a two- or four-year degree, and can pay less than \$40,000 a year. Someone who second-guesses a doctor’s opinion, and a specialist working regularly with her department at that, could derail her career.” (Clifford 2020) Lacking medical expertise, caseworkers lean heavily on the doctor’s guidance, regardless of its accuracy.

Professionals in child welfare rely heavily on doctors’ diagnoses of abuse. Lacking medical expertise, they depend on the doctor’s advice, even if the doctor has misdiagnosed the circumstances. When a misdiagnosis occurs, child welfare staff present inaccurate information to judges, unintentionally misrepresenting the situation. Trusting the doctors’ word, a caseworker may build cases against innocent parents, never realizing the doctor erred.

Child welfare workers must still understand that they are the first line of defense. They should closely examine any isolated child abuse incident to determine if it was accidental or part of a pattern, even if it means questioning a doctor’s diagnosis. While developing relationships with doctors is natural, these bonds become problematic when staff becomes too trusting of a diagnosis. Child welfare personnel must think critically, remaining open to rare medical conditions rather than concluding isolated events that indicate repeated abuse.

When child welfare sees a solitary event or a family demonstrating affection, this information must make it into case files. They should also seek unbiased second medical evaluations instead of relying solely on one doctor or set of doctors from the same network.

The county must provide the tools and support for unbiased advocacy focused solely on children’s best interests. By fostering a supportive environment, the County will equip its child welfare staff to ensure all families under scrutiny receive fair, balanced assessments.

THE DETECTIVE’S ROLE

Detectives may take the lead in investigating child abuse allegations. They interview all parties involved to understand what occurred. Detectives actively collect evidence to determine how the child sustained an injury. These investigations include gathering medical records, meeting with teachers, neighbors, family members, and visiting the home environment. They reconstruct timelines leading up to the incident. Detectives analyze all facts to establish what took place and who bears responsibility.

Once detectives compile evidence, they decide whether abuse transpired or an accident better explains the injuries. If detectives confirm maltreatment, they identify the perpetrator.

Detectives and caseworkers act as fact-finders to reconstruct reality. Their impartial investigation techniques should uncover the facts of the matter.

To avoid accidentally accepting a misdiagnosis, detectives should proactively investigate medical conclusions, especially in cases where doctors have conflicting diagnoses. In this case, they should report that conflict to the court.

Teaming up with caseworkers, they should interview the child's other doctors to understand their complete medical history and any conditions that could explain injuries.

Detectives must thoroughly follow up on all leads before removing a child from their family. They must remain impartial seekers of truth who use their skills to uncover facts. Their careful legwork provides the objective evidence needed to separate truth from speculation.

JUDGES AND MASTER'S ROLE

In a child abuse case, the courts often use masters, also known as Juvenile Court Hearing Officers. Masters play a vital role in child abuse and neglect cases. Courts appoint masters to conduct hearings, review evidence, monitor case compliance, and recommend to the presiding judge matters like custody, services for the family, permanency planning, and the termination of parental rights. Masters are valued for their expertise in child welfare and ability to gather details on the case's complex circumstances. Their findings and suggested orders help guide judges in making well-informed final decisions. One area where challenges arise is the reliance of judges and masters on medical professionals. Judges and masters do not have all of the insights or skills that a doctor does. They must rely on these professionals.

Judges and masters heavily depend on information from doctors, particularly when diagnosing child abuse or medical neglect cases. They trust doctors will be truthful and provide accurate assessments based on their expertise.

The courts must move cautiously when medical evidence is presented or contested among specialists. The courts should be skeptical of any doctor claiming definitive findings of abuse without solid proof. Doctors should only diagnose medical conditions. It is not their job to decide who abused the child. Detectives, not doctors, should determine who abused the child.

It is crucial to ensure mechanisms are in place to verify and corroborate medical assessments to strengthen the system and address these issues. Judges can seek second opinions or consult with other medical experts to validate diagnoses, especially when the potential consequences involve the removal of a child from their caregivers. By implementing such measures, the system can mitigate

the risks associated with misplaced trust and promote a more reliable and accountable approach to decision-making.

It is vital to acknowledge the existence of these vulnerabilities within the system and strive to address them through improved safeguards and mechanisms for verification. By doing so, we can work towards a more robust and reliable child abuse system that better serves the interests of both children and their parents.

THE ROLE OF A HOSPITAL'S CHILD PROTECTIVE UNIT (CPU)

A hospital's Child Protective Unit, or other preferred nomenclature, coordinates responses to child abuse allegations in the community. The unit is typically housed within the hospital and includes partnerships with local law enforcement, child welfare, and prosecution. The appendix contains the memorandum of understanding explaining the structure of this agreement.

While CPUs provide valuable resources, they have faced some critiques:

- Perceived conflicts of interest: Some feel this compromises neutrality and objectivity in investigations since the CPU is part of the hospital. There are concerns about institutional bias.
- Self-reporting issues: Doctors in the hospital uncover abuse and must report it to child welfare authorities. However, since the CPU is part of the hospital, those child abuse reports get referred back to the CPU/hospital for investigation. This situation creates a self-reporting loop that some argue is problematic.

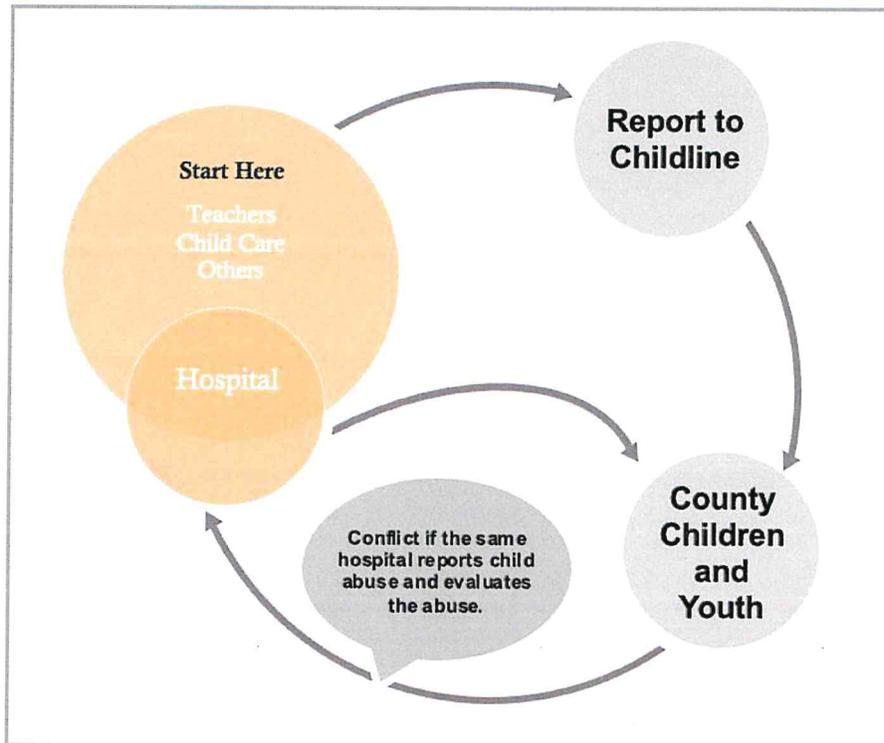


Figure 4: Self Reporting Loop

- Inconsistent use: The CPU is not used for every child abuse investigation in Lehigh County. The criteria for when the CPU does or does not get utilized is unclear to the controller.
- Lack of transparency: Limited public information is available concerning the CPU's processes, operations, governance, and results.

While a CPU provides vital services, addressing these potential conflicts, self-reporting issues, inconsistent use, and transparency concerns could improve public trust and mitigate risks in the county's child abuse response system. Limited transparency fuels speculation about CPU operations. As an integral part of Lehigh County's child welfare infrastructure, reforming perceived deficiencies with the CPU could bolster community confidence.

THE DOCTORS POWER

In practice, doctors hold tremendous influence over child abuse cases. Their medical opinions tend to be accepted without challenge, even if possibly flawed. The system assumes doctors arrive at accurate findings when they can make harmful mistakes, as in any profession. The system must equip

professionals that rely on doctors to critically analyze medical evidence instead of automatically trusting a potentially mistaken doctor. More oversight of abuse diagnoses is needed.

Findings

OBSERVATION 1: CONTROVERSY OF MCA DIAGNOSES

Part A: The Nature of Munchausen Syndrome by Proxy (MSBP)

MSBP represents a severe and rare form of child abuse. Despite its severity, MSBP is exceedingly rare. There is controversy over the diagnosis because a diagnosis in a child automatically leads to a diagnosis in the caregiver (typically the mother) without requiring the caregiver to undergo any evaluation.

Part B: The Complexity of the MSBP Diagnosis

Pediatricians are often the doctor that diagnoses MSBP. It's crucial to highlight the difference in diagnosing physical and psychological conditions. For instance, a broken arm is a direct, physical diagnosis confirmed through imaging techniques. Doctors are not saying who broke the arm, just that it broke and looks like it was on purpose. MSBP is an indirect psychological diagnosis confirmed through a process of elimination and behavioral observation. The problem is that the doctor is diagnosing **who** is harming the child. In this case, the doctor officially indicates that a caregiver is or is not abusing the child.

Here are Some Key Things a Doctor Does to Diagnose MSBP (Stirling 2007):

- Distinguish between exaggerated, imagined, induced, or fabricated symptoms, noting undetectable or inconsistent signs
- Evaluate if the disease symptoms align with known medical patterns and compare against common illnesses
- Place factitious disease in the list of potential diagnoses, especially if symptoms do not fit known patterns
- Collect comprehensive information from all medical professionals involved to form a holistic understanding of the child's health
- Seek observations and insights from nurses, support staff, and other medical personnel regarding the child and family
- Assess if there is a pattern where common illnesses resist standard treatments or if treatments escalate without improvement

- Consult with multidisciplinary teams, such as psychologists and social workers, to gain more insight
- In situations of imminent harm, employ covert videotape surveillance to observe the child's interactions and verify symptom consistency, ensuring adequate safeguards are in place

The diagnosis requires piecing together a pattern of behavior and evidence over time. No single finding confirms MSBP - it is a determination made only after doctors rule out all genuine disorders.

When pediatricians diagnose Munchausen syndrome by proxy, they accuse the caregiver of MCA, often without even performing a psychological evaluation of the caregiver. Furthermore, the additional opinions should not be from another pediatrician. It should be a specialist in the purported disease the parents claim the child has. A psychological assessment of the caregiver should be required before labeling a parent as abusive (Anderson 2016).

All of these misdiagnoses cost taxpayers money.

Part C: Anomalies in the Northeast Region of Pennsylvania

The Northeast region of Pennsylvania, encompassing 14 counties, has an unusually high number of “substantiated reports” of MSBP, as defined by the child protective service. Despite representing only 11% of the total population under 18, this region accounts for 40% of the total cases of MSBP.

Among the 14 counties in the Northeast region, MSBP cases have been relatively limited, with only four counties reporting cases between 2017 and 2021. However, it is noteworthy that Northampton County and Lehigh County accounted for a significant majority, specifically eight out of the ten reported cases in the Northeast region. These cases represent approximately 32% of all MSBP cases reported in Pennsylvania over five years, despite the counties of Northampton and Lehigh having a combined population that is less than half of Philadelphia's, which only had seven reported cases during this same period.

The consistency of the outlier status over two consecutive years, and the absence of reports in Northampton County coinciding with Lehigh County's first two consecutive cases of MSBP, suggests that these findings are unlikely to be random occurrences. The statistical significance of the outlier further supports the notion that *these are abnormal conditions rather than natural variations* within the standard deviation.

Furthermore, Scott Bailey, Ph.D. the Chair and Professor of Psychology at Texas Lutheran University, statistically reviewed the medical child abuse data provided by DHS and concluded:

Given the seriousness of child abuse and the rarity of Munchausen Syndrome by Proxy, close examination into what is driving the high number of diagnoses in the Northeast region generally...

appears not only merited but urgent.

Part E: Controversies Involving CPU doctors

CPU physician testimony has been controversial in Pennsylvania, Florida, and New York. There are multiple instances where judges have challenged the testimony of a CPU physician. Some judges have even questioned the validity of their expert testimony while recognizing them as experts in their field. These cases include the diagnosis of MCA, MSBP, and other diagnoses of child abuse. In one example case, a child under eighteen was alleged to suffer from abuse. The judge's comments appear below:

Judge: Hon. Edwina G. Richardson

"The court is saddened by what has happened here as a result of an insufficiently substantiated accusation of Shaken Baby Syndrome. [The doctor's] failure to identify and adequately rule out the various potential causes of bilateral subdural hematomas in this child, and her misdiagnosis of the child as suffering from subarachnoid bleeding, caused her to jump to many conclusions, including the conclusion that the child's injuries were caused by violent shaking. There are far too many abused children in our society. This court's role is to try to ensure, to the extent possible, that children are protected from abusive and neglectful parents. It is tragic that a medical misdiagnosis and an inappropriate rush to judgment has resulted in these loving, caring, dedicated parents being separated from their sickly child. Thankfully, in this case, visitation has been liberal."

In another case of child abuse: **Judge: Hon. Jeanette Ruiz**

Based on the totality of the evidence presented the Court finds Petitioner has failed to prove by a preponderance of the evidence the subject child suffered from non-accidental head trauma (NAHT). The evidence showed the child was diagnosed and treated for presumptive meningitis during his first hospitalization... Three of the four medical experts who testified as to the child's diagnosis and treatment agreed, to varying degrees, that the child had either viral or bacterial meningitis during his first hospitalization. Only [the CPU physician], Petitioner's expert during their case in chief, opined the child suffered from NAHT during this first hospitalization.

Part F: Dependence on CPU Physician Expertise

Lehigh County's CYS department heavily relies on a CPU's expertise when investigating child abuse allegations. Judges often base their decision to issue an order for removing a child from their caregivers on the information provided by caseworkers and the insights and evaluations from physicians with the CPU.

Recommendation 1: Establish a Neutral Review of Diagnoses

The controller's office strongly recommends that Lehigh County Children and Youth Services and Lehigh County judges require at least a second medical opinion in cases where child removal is a possible outcome. A second opinion may not be necessary if there is immediate danger to the child which should coincide with clear evidence of a pattern of abuse. Such evidence can include but is not limited to, cigarette burns, beatings, starvation, isolation, severe burns, a history of unexplained bruises, violence in the home, multiple 911 calls, sibling injuries, or multiple prior reports of concern from schools or religious organizations. The exact criteria should be suggested by experts in this field. - The second opinion should be obtained from a medical professional from a different hospital network or CPU than where the first diagnosis was made. - The second opinion should be from a medical professional with experience or expertise in the appropriate specialty applicable to the case.

Furthermore, when evaluating cases suspected of MSBP or MCA, the controller's office suggests that CYS utilizes a multidisciplinary team to assess the child and caregiver. This team should comprise professionals from diverse areas of expertise outside of a single hospital network, providing a comprehensive perspective on each case. This approach will help ensure the accuracy of diagnoses and safeguard the well-being of the children and families involved. This approach should continue even after the completion of an investigation.

Recommendation 2: Request Hospitals Conduct an Investigation

The Lehigh County Board of Commissioners should instruct the Lehigh County Solicitor to prepare and send correspondence to the heads of local hospitals. The correspondence should convey the following:

Due to the unexpectedly high number of MSBP cases in the Northeast, the Lehigh County Board would like certainty that this facility and its associated providers is providing the County of Lehigh and its residents with child abuse services free from misdiagnosis. Therefore, the Board requests:

- An investigation into all MSBP diagnoses and all associated aliases made within the past five years by medical professionals affiliated with your hospital.
- An investigation into all instances where a child was removed or an attempt was made to remove a child from their caregivers over the past five years, without prior indication of patterns of abuse as outlined above.

A neutral third party, with no past or present association with the hospital or the County of Lehigh, should conduct all investigations. Both entities must mutually agree on this third party.

The report shall be public, and the results uploaded to the Lehigh County Government website in compliance with the privacy requirements of the CPSL.

Recommendation 3: Hire an External Expert for Case Review

The Lehigh County Board of Commissioners should hire an external expert familiar with child abuse diagnosis and the best practices of a children and youth agency. This expert should review all MCA and other cases where a parent was “indicated” in the last five years where there was no clear evidence of a pattern of abuse.

The external expert would also review how these cases were managed internally and the county’s overall process and procedures.

Recommendation 4: Rectifying the Consequences of Misdiagnosed MCA

The county should urge all relevant providers to remove/change the diagnosis of MCA or any of its aliases from a patient’s medical records, especially in cases that have been withdrawn or based on the outcome of Recommendation #3. This step is crucial since such a diagnosis can significantly impact a patient’s life and may reduce the patient’s likelihood of taking further legal steps. In an article titled “Sometimes, an apology can deter a lawsuit,” the California Bar Journal examined the impact that an apology can have on the likelihood and cost of lawsuits. It found that,

“The VA Medical Center in Lexington, Ky., the pioneer in full disclosure, reported that in a 13-year period, the facility went to trial only three times and negotiated more than 170 settlements, the mean cost being \$36,000 compared to \$98,000 pre-trial, \$248,000 at trial and \$413,000 malpractice judgments at VA hospitals nationwide.” (Curtis, n.d.)

The lesson here is that if healthcare providers willingly, rather than being forced to, change a diagnosis of MCA, it may be less likely that an aggrieved parent files a lawsuit or at least demands less in damages.

An incorrect diagnosis of this nature follows a patient into adulthood and can lead to significant consequences. One such instance is demonstrated in a case represented by Ms. C, the lawyer for the parent being accused of “fictitious disorder by proxy,” another term for MCA or MSBP.

17 MS. C [REDACTED]: He is working with the
18 family. I wanted to add I think there was a
19 personnel -- a person at the school who's no
20 longer employed or working with them. And the
21 family can speak to that.
22 But I also think there was an issue
23 with the original reason they came here was with
24 the fictitious disorder. But because of that
1 reluctant to do the -- the initial issue was
2 that they were like, okay, since the children
3 don't have issues because there's this
4 fictitious diagnosis, so these kids don't have
5 issues. So we're not going to do the IEP.
6 We're not going to do the 504 plan because it's
7 certified by the fact that mom has this
8 diagnosis. So I think that's caused some
9 conflict with the school. Not some. I believe
10 a lot.

Figure 5: Court Documents

The above excerpt from a court transcript shows Ms. C explaining to the judge how an erroneous diagnosis prevented a child from getting the educational support they needed. The school denied the child a 504 plan and an individualized education program (IEP) because of the “fictitious” diagnosis, alleging the parent was fabricating the child’s symptoms.

A 504 plan provides accommodations for disabilities that limit major life activities, such as learning, including extra time on tests. An IEP is a legal document that provides specialized instruction and services for special education students tailored to the child’s needs.

The ramifications of an incorrect diagnosis extend beyond education, particularly as the child grows into adulthood:

- Eroding trust in healthcare providers—A disputed diagnosis can create skepticism towards doctors, making individuals hesitant to seek care.
- Creating barriers to medical care—Some providers might refuse treatment due to the liability risks associated with a disputed childhood diagnosis.
- Limiting health insurance options—Insurers may deny coverage for patients with disputed diagnoses like MCA.

- Undermining patient autonomy—Providers may dismiss or doubt the reliability of a patient’s symptoms based on their medical history.
- Making record correction challenging—It can be complex for patients to get inaccurate diagnoses removed or corrected in their medical files as adults.

A misdiagnosis of this nature can have far-reaching detrimental effects on a person’s health, relationships, and overall well-being. Therefore, the removal/change of such a diagnosis seems important.

Recommendation 5: Training Caseworkers and Managers at Children and Youth Department

Caseworkers at the Children and Youth Department play a crucial role in investigations related to child welfare. They are responsible for documenting and “indicating” a caregiver when potential abuse is suspected. Given the gravity of such accusations, the county must provide thorough training to these caseworkers. Specifically, when a doctor diagnoses a case as MCA, caseworkers should be well-informed about the signs and symptoms. They should not merely accept the diagnosis at face value. Instead, they should critically evaluate the evidence provided by the doctor, especially in situations where different doctors have identified other potential diseases in the child. Moreover, caseworkers should receive training on rare diseases that mimic the signs of MCA but are genuine medical conditions. This will ensure a fair and accurate assessment of each case, protecting the child and the caregiver from potential misjudgments.

OBSERVATION 2: POTENTIAL OVER-CLASSIFICATION OF CHILD ABUSE

Part A: Reporting Procedure and Mandatory Reporters

The reporting process for suspected child abuse in Pennsylvania starts with an electronic system called ChildLine. It is here that mandatory reporters log their suspicions about possible child abuse. Mandatory reporters include, but are not limited to, school employees, anyone licensed or certified under the Pennsylvania Department of State to practice in a health-related field, medical examiners, coroners, or funeral directors. A more comprehensive list can be found on Pa Family Support Alliance

Individuals who are mandatory reporters must report any suspected child abuse or neglect. They must uphold this duty even if the indicators of abuse or neglect are uncertain. Often, the reporter is unsure if the issue is harmless. The mandated reporters are taught to be overly cautious to protect our children. They must trust the process and assume the people evaluating abuse have the entire family’s best interest in mind.

Part B: Signs and Consequences

Reporters look for signs of abuse, such as physical indications (bruises, burns, and broken bones) or neglect (constant hunger, unsuitable clothing, and poor hygiene). Sometimes, however, the signs are less distinct, and suspicion might not be based on clear-cut evidence. Regardless, if a reasonable suspicion arises, a report should follow.

Failing to report suspected abuse can lead to severe penalties, but the law protects those who report it. This approach encourages more reporting rather than less. Every report made through ChildLine is directly forwarded to the appropriate county's child welfare agency, which in Lehigh County is CYS.

Part C: Investigation Process, Outcomes, and Status Definitions

When a report of possible child abuse is received, an investigation must commence within 24 hours and conclude within a maximum of 60 days. The investigation's end can result in one of three possible outcomes: "unfounded," "founded," or "indicated."

1. "Unfounded": Indicates that the investigation found insufficient evidence to support the claim of child maltreatment.
2. "Founded": Assigned when a court ruling confirms that child maltreatment has occurred. In these cases, all involved parties can present their cases.
3. "Indicated": Assigned when CYS finds substantial evidence of abuse through investigation or admission by the accused. This status does not require a judge to review evidence. *OPINION: The controller's office believes investigators take a conservative approach, marking cases as "indicated" if the investigator is unsure if the case should be indicated or unfounded.*

There's also a "Pending" status, assigned when the investigation cannot be completed within 60 days specifically due to initiated court action. We did not look at the status of "Pending."

ChildLine, Pennsylvania's state-run child abuse hotline, maintains a database with these status records for alleged perpetrators. Besides handling reports of potential child maltreatment and forwarding them to the appropriate CYS agency, ChildLine staff also conduct background checks for those wanting to work or volunteer with children.

The term "substantiated report" corresponds to an "indicated" or "founded" status. However, it can be misleading. While "substantiated" might imply a confirmed case of abuse, it is assigned without a court hearing or the ability of the accused to defend themselves. Once a status of "indicated" is given, ChildLine considers the accused person an abuser. Understanding this distinction is essential to ensure the proper interpretation of ChildLine records.

Part D: More Than 790 People Were Potentially Mislabeled as Child Abusers in Lehigh County Due to State Laws (n.d.)

If a person is “indicated,” they can appeal the decision. The Pennsylvania Department of Human Services’ Office of Children, Youth, and Families (OCYF) conducts administrative reviews through a dedicated panel if appealed. If the person appealing the case wins, the panel removes their name and personal details from the ChildLine and abuse registry database.

It’s important to note that the OCYF’s review panels almost **always** support the initial decisions made by the county children and youth agencies (CCYAs). To put it in perspective, since 2013, the panel has upheld decisions at an incredibly high rate of above 99%.

In cases where either side disagrees with the panel’s decision, they can request a hearing from the Bureau of Hearings and Appeals (BHA). Parents are entitled to appeal directly to BHA and skip the OCYF review if they prefer.

In stark contrast to the OCYF’s tendency to uphold decisions at an average rate above 99%, the BHA—the body responsible for holding **evidence-based hearings** for those who promptly demand such action - has consistently overruled a supermajority of the “indicated” reports. Over the years, the BHA has overturned 91% of these reports in 2021, 94% in 2020, and 91% in 2019, according to the annual reports of the DHS. **This means that less than 10% of the time, the BHA has sustained the initial “indicated” findings of investigators, demonstrating a gross discrepancy between the two reviewing bodies.**

Using concrete figures, it becomes even more apparent that a significant issue exists. Between 2016 and 2021, Lehigh County saw 886 cases deemed substantiated. Given the BHA’s average overturn rate of 90%, it’s possible that approximately 797 people incorrectly received the label of child abusers—likely upending the lives of hundreds of children, caregivers, and relatives and costing taxpayers money.

Recommendation 1: Child Abuse Protection Policy Reforms are Urgently Needed in Pennsylvania

The General Assembly of Pennsylvania, especially the Senate, the House, and the representatives of the children and youth committees, must now overhaul our state’s child abuse protection system. Considering the recent Commonwealth Court decision in *S.F. v. DHS*, teachers must now receive a hearing before being named perpetrators on the ChildLine registry. Ongoing litigation seeks to extend that protection to all workers and caregivers in Pennsylvania, but there is no need to delay until the conclusion of the constitutional case. The general assembly can use child protection laws from states

like Delaware and Texas as models for reform. Both states have taken a better approach to protecting kids first and foremost but also protecting parents from overzealous doctors or caseworkers.

Some major policy issues related to child abuse in Pennsylvania include:

- Mandated reporting laws need clarification, as requirements are currently vague and inconsistent
- Child abuse laws and definitions are outdated and should be aligned with federal standards
- More rigorous oversight and accountability procedures proposed for child welfare agencies [<https://www.paycaa.org/aws/PCAYAA/pt/sp/recommendations>]
- The language of “indicated” and “substantiated” should be changed not to give a false impression that a parent has been found guilty of child abuse
- A parent who is “indicated” should **not** be disclosed as being on the child abuse registry
- When Child and Youth Services (CYS) investigates abuse allegations and involves entities such as medical providers, employers, or family, they should issue clearance letters if they later find these claims unfounded or expunge them. These letters, sent to all initially notified, confirm that the accusations were unproven and help rehabilitate the accused’s reputation. Mandating CYS to issue clearance letters for unsubstantiated allegations can offer essential updates and initiate the repair of any reputational harm caused by the initial investigation notifications
- Clearer guidelines are needed describing when a child can be removed from the home for suspected MCA. Removal should not occur based only on one doctor disagreeing with a prior diagnosis. There should be concurring opinions from multiple specialists in the field of the initial diagnosis before disputing it. Requiring expert confirmation of the specific medical condition would help prevent inappropriate child removals and allegations of MCA arising from diagnostic disagreements.

Recommendation 2: Governor of Pennsylvania: A Call to Address the Indication Status Controversy

The Governor of Pennsylvania, without any further delay, should sign an executive order that stops all public disclosure of the “indication” status.

Although there might be opposition, it is important to note that these “indications” are issued without due process. As a former Attorney General, the Governor knows the significance of due process and the current violation of people’s rights.

OBSERVATION 3: FLAWED “INDICATED” DETERMINATION PROCESS COSTS FAMILIES AND COUNTY

The current procedures for determining an “indicated” status on the Childline registry appear unconstitutional and functionally unworkable. Critical issues identified include:

1. **Guilty Before Proven Innocent:** The process fails to provide due process rights to the accused, only allowing these rights after a damaging and potentially incorrect “indicated” determination has been published. Parents cannot present their side of the story or evidence to a judge. Their only hope is that the evidence provided to a caseworker will be used in good faith. An indication signifies you are a child abuser. There is very little difference between having a status of “founded,” which is done by a judge, and “indicated,” which is set by a caseworker.
2. **High Appeal Success Rate:** Data from the Pennsylvania Bureau of Hearings and Appeal (BHA) from 2019 to 2021 shows that over 90% of “indicated” determinations are overturned on appeal. Such a high reversal rate suggests systemic problems in the initial determination process and is alarmingly inconsistent with the typical appeal success rates in U.S. federal courts.
3. **Inconsistent Application of “Substantial Evidence” Standard:** The current process results in uneven determinations due to varying interpretations of “substantial evidence” of abuse. Often without the educational background to assess conflicting medical opinions, caseworkers must make determinations, sometimes based solely on medical records.
4. **Time Constraint Pressures:** The 60-day decision window may unintentionally encourage caseworkers to prematurely determine an “indicated” status, especially if they feel time-pressured and lean toward caution.
5. **Economic Burden:** This overreporting results in considerable taxpayer dollars being expended and state resources being consumed for an issue that, as appeal rates suggest (over 90%), does not usually exist.

In essence, the current procedures for “indicated” determinations appear to jeopardize financial resources of the County. Please also see Auditor General’s report *‘State of the Child’ report to improve protection for at-risk children* (DePasquale, n.d.)

Recommendation 1: Executive Review of ‘Indicated’ Cases & Decision of Non-Pursuit:

When an individual with an “indicated” status has navigated through the required processes and is awaiting a BHA hearing, they should have the option to seek a review from the county executive within some reasonable time and provide a letter back to the requestor with reasoning. If, upon review, the county executive determines that the case does not have sufficient grounds, the appropriate county

authority should send a Notice of Non-Pursuit to BHA, leading to the immediate termination of the case. This will save taxpayers money by eliminating additional solicitors and other resources focusing on this issue.

Recommendation 2: Mandating Stronger Case Assessments Ahead of Indication

Given the lengthy process and multiple stages that precede the BHA review, it is concerning to note that 90% of indicated cases are overturned at the BHA stage, often after a year or more has passed. Initially, caseworkers are granted 60 days for a review, which aims to provide ample time to assess whether strong evidence supports a case or if they can obtain enough evidence to support a claim. If, at this juncture, a caseworker does not believe their case is robust enough to eventually stand up to BHA scrutiny, an alternative route should be pursued rather than opting for indication.

The county executive should mandate a thorough re-evaluation of this process and the alternatives available. The goal should be to protect children from abuse and caretakers from unduly being indicated. Until state laws change, the county should ensure that only cases with substantial evidence proceed to indication, avoiding undue stress and consequences for individuals and families and conserving county resources.

OBSERVATION 4: CONCERNS OVER REFERRALS

Caseworkers in Lehigh County are responsible for referring parents and children for evaluations encompassing various services. These services may include but are not limited to individual therapy, family counseling, psychological evaluation, mental injury evaluation, and forensic counseling.

A pattern emerged during our review: A single service provider contracted with Lehigh County, was frequently mentioned by families. Parents expressed a concern that they were being directed specifically to this organization by the caseworkers. The families also said they were told that the county would pay for the services of this one provider, but if the families wanted to use their own provider, they would have to pay out of pocket. The county's expenditure on just one provider was more than \$106k in 2021, over \$66k in 2022, and already exceeding \$68k in 2023, with projections to spend more than \$100k by year's end. These expenses were not only by CYS but by other agencies in the county as well.

Recommendation 3: Implement an Allowance System for Families

CYS has an established relationship with service providers and a list of contracted rates specified for various services. To further alleviate any appearance of impropriety, CYS should consider offering fam-

ilies an allowance system. Under this approach, families may utilize one of CYS's contracted service providers or select their own properly credentialed provider. CYS would cover costs up to the average contracted rates, and families would be flexible to negotiate further with their chosen provider or pay any difference if they wish. This policy would empower parents with more control over the services they receive while maintaining financial fairness and transparency.

Recommendation 4: Outside Evaluation

In other sections of this report, we emphasize the need for a third-party evaluation of CYS's specific processes. This evaluation should also scrutinize the county's vendors to ensure that there is no unnecessary bias.

OBSERVATION 6: "IT'S THE STATE'S FAULT."

Initially focused on Munchausen syndrome by proxy (MSBP), the investigation soon uncovered potential misdiagnoses in other types of child abuse, such as shaken baby syndrome, various forms of head trauma, and brittle bone disease.

There is a widespread belief that many of these issues are due to current state child protective laws. While this reasoning has merit, the laws in question have significant flaws, such as:

- Disregarding the due process rights and reputational protections guaranteed by the Constitution of the Commonwealth of Pennsylvania
- Tarnishing a person's reputation without a hearing
- Denying individuals a fair opportunity to be heard
- Classifying and disseminating names as child abusers without due process

In the meantime, children are being removed from their parents, and parents are being labeled as child abusers in the eyes of the state. Lehigh County is central to this issue; thus, county officials must find the reasons for these oversights.

The Bureau of Hearings and Appeals (BHA) has overturned 90% of the indicated reports appealed to it over the past three years. This figure is not a statistical anomaly; it is an obvious sign of systemic failure. The blame for this failure lies with the process and procedures suggested by the state and implementation within counties.

The challenges faced by frontline caseworkers further complicate the situation. They are burdened with excessive cases and operate in an environment plagued by low morale, ambiguous promotional processes, and the constant fear of losing their jobs. Feedback from former caseworkers indicates that they feel that promotions often favor those who conform to management's views rather than

those with the necessary skills. Whether this is true or just a perception makes little difference in the outcome. These factors, coupled with the complexity of the cases they manage, create a situation that needs to be reviewed.

While Lehigh County, statistically, doesn't seem to be an outlier in the number of people that it "indicates," and the state's laws may be flawed, the county needs to undertake an effort to resolve these issues to the best of its ability.

Recommendation: Comprehensive Third-Party Review of Child Protective Processes

Based on the observation and the potential systemic failures in handling child abuse cases, including possible misdiagnoses and the disregard for due process rights, it is imperative to take immediate and decisive action.

1. **Hire an Independent Third Party to Review Processes:** Engage an independent third party to conduct a comprehensive review of the child protective processes in Lehigh County. This review should include an in-depth analysis of specific cases, management practices, caseworker turnover, and the overall process that leads to indications.
2. **Involve Service Employees International Union (SEIU) to Increase Collaboration:** To ensure the credibility and acceptance of the review, allow the SEIU state management or national management to recommend and participate in selecting the third-party reviewer. The caseworkers in Lehigh County are members of SEIU, and their representation in this process will help alleviate any concerns that the workers may dismiss the results. The administration must then ensure that management recognizes the results. It must be a collaborative effort.
3. **Evaluate Caseworker Environment:** Investigate the working conditions of the frontline caseworkers, including the burden of excessive cases, morale, promotional processes, and fear of job loss. Understanding these dynamics is crucial for addressing the root causes of errors and over-indication.
4. **Public Disclosure of the Report:** The third-party review should make the findings and recommendations public while strictly adhering to the privacy of individuals. Transparency is essential for rebuilding trust and demonstrating a commitment to rectify the identified shortcomings.
5. **Implement Recommended Changes:** Act promptly on the recommendations provided by the third-party review. These actions may include reforms in management practices, management structure, procedural changes, training, support for caseworkers, and other necessary measures to protect the rights and well-being of the children and families involved.
6. **Ongoing Monitoring and Accountability:** Establish regular monitoring and reporting mechanisms to ensure that the implemented changes are effective and that the system is accountable

for continuous improvement.

A comprehensive, independent, and transparent review, followed by decisive action, is essential to the child protective processes and ensures that the rights and well-being of children and families are upheld.

OBSERVATION 7: COMPLIANCE CONCERNS IN LEHIGH COUNTY OFFICE OF CHILDREN AND YOUTH SERVICES (OCYS) CONTRACTOR OPERATIONS

While we investigated the costs associated with misdiagnosis and overdiagnosis, we found a relevant recommendation from the office of the Auditor General. During FY2020 & FY2021, the Pennsylvania Auditor General and external financial auditors (ZA) raised significant concerns regarding contractors' compliance with the Lehigh County OCYS potential in-house processes with established standards. Reference can be made to the "Special Note" on page 18 of the Auditor General's report. This note highlights that the Lehigh County OCYS faced challenges in allocating funds for essential contractor inspections and ensuring proper licensing of contractors and subcontractors. However, the 2021 Lehigh County single audit report indicates improvements, as documented in the "Summary Schedule of Prior Audit Findings" on page 26.

Recommendation: Budget Prioritization for Legal Compliance in Lehigh County OCYS

Adherence to laws and regulations and upholding a high standard of client care is crucial for all county management functions. The Lehigh County OCYS must ensure adequate contractor inspections and licensing budget allocation. Additionally, contractors, particularly those responsible for pediatric diagnoses, must be rigorously vetted and regularly monitored. Internal LCO processes should also be assessed to guarantee compliance with the prevailing standards. We further suggest that the county allocate a budget in this fiscal year to start this process.

Glossary of Terms

- **Bureau of Hearings and Appeals (BHA).** Is an administrative law judge system that hears appeals from individuals who have been denied or terminated from receiving cash assistance, medical assistance or Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as food stamps. It also hears appeals regarding the maintenance of the permanent record of founded or indicated child abuse in the central state registry and disputes regarding reports of elder abuse to the Department of Aging
- **Caregiver Fabricated Illness:** This subtopic emphasizes the central role of the caregiver in fabricating or exaggerating symptoms in the child. It highlights the power dynamics at play, where the caregiver assumes control over the child's medical narrative, often seeking attention or validation for themselves through the child's illness.
- **Caseworker:** The social worker responsible for the care and well-being of children and youth who need protection or services. They work with families to assess their needs and develop plans to ensure the safety and well-being of children. Caseworkers also support families to help them overcome challenges and improve their lives.
- **Child Protective Services Law:** It is best to review definitions on the PA website as they may change occasionally. PA Child Protective Services Law.
<https://www.legis.state.pa.us/WU01/LI/LI/CT/HTM/23/00.063..HTM>
- **Childline:** ChildLine is a required state program to receive reports of child abuse and concerns about a child's well-being. It ensures that these reports are promptly sent to the right agency for investigation.
- **Demedicalization:** A term often misused to mean that after the child is admitted to the hospital, the medical team chooses to discontinue all medications and treatments the child has been receiving. This step is taken to observe whether the symptoms persist or resolve without those medications.
- **Emergency Custody:** The legal process of taking a child into custody when there is an immediate danger to the child's safety and welfare.
- **Fabricated or Induced Illness:** A medical child abuse diagnosis that focuses on the manifestations of MSBP in children, highlighting that the illness is either fabricated (nonexistent) or induced (caused deliberately) by the caregiver.
- **Factitious Disorder by Proxy (FDBP):** A medical child abuse diagnosis that encompasses the broader concept of MSBP, emphasizing the presence of a factitious disorder in the caregiver. The caregiver's behavior stems from a complex set of internal drives and incentives, frequently rooted in a longing for affection, compassion, or authority that manifests in paternalistic actions.
- **Factitious Disorder Imposed on Another (FDIA):** A medical child abuse diagnosis that emphasizes the psychiatric nature of MSBP, highlighting that the caregiver is intentionally fabricating

or inducing symptoms in another individual, typically a child. It underscores the underlying psychological motivations and the deceptive behavior exhibited by the caregiver.

- **Founded Status:** A status assigned to the perpetrators' record in the PA Child Abuse Registry. This status is set when a court ruling confirms that child maltreatment has occurred. In these cases, all involved parties can present their cases.
- **Indicated Status:** This classification is assigned when CYS identifies considerable evidence of abuse through their investigation or the accused's admission. This status may also be employed when further investigation or medical information is necessary.
- **In-home Service Provider:** Refers to a continuum of prevention-related supports and programs designed to enhance the protective capacity of caregivers and improve the conditions that may contribute to safety and risk concerns for children provided in the child's home.
- **Johns Hopkins Hospital:** A nonprofit academic medical center that sets healthcare standards in patient care, research, and education. It is regarded as one of the world's most outstanding hospitals and medical institutions. For 21 consecutive years, from 1991 to 2020, it was ranked as the best overall hospital in the United States by U.S. News & World Report.
- **Kinship Care:** A term used to refer to the full-time care of a child by relatives and suitable others. Suitable others refer to unrelated kin or close family friends.
- **Lehigh County Children and Youth Services (CYS):** The government agency that filed allegations of medical child abuse against the parents. A part of child protection services (CPS) and also known as the Office of Children and Youth Services (OCYS).
- **Mandatory/Mandated Reporters:** Individuals whose jobs involve frequent encounters with children. Teachers, childcare workers, and pediatricians are examples of mandatory reporters. They are required to report any knowledge or suspicion of child abuse and are uniquely positioned to identify and report suspected abuse or neglect.
- **Masters:** A name used to refer to a Juvenile Court Officer.
- **Medical Child Abuse (MCA):** Also known as Munchausen syndrome by proxy (MSBP). This child abuse occurs when a caregiver, often a parent, either fabricates, exaggerates, or induces health problems in a child for various reasons, usually to draw attention or sympathy. This behavior can lead to unnecessary and potentially harmful medical procedures being performed on the child.
- **Munchausen Syndrome by Proxy (MSBP):** A mental health condition in which a caregiver makes up or causes an illness or injury in a person under their care, such as a child, an elderly adult, or a person with a disability. Because vulnerable people are the victims, MSBP is a form of child abuse or elder abuse.
- **Orion:** The pseudonym of the older child in the narrative. This child was taken to the ER due to concerning behavior changes.
- **Parent's Medical Rights Group:** A medical activist group. The stated goal of this group is to support parents in developing, educating, and expressing their parental rights. They believe

parents have the right to partner with doctors, clinicians, hospitals, and insurers to decide the best practices for care in keeping children healthy. They also want to ensure parents have a voice and a seat at the table for every aspect of their children's medical care. They are based in the Lehigh Valley, Pennsylvania, but they aim to serve parents from all 50 states.

- **Shelter Care Hearing:** This hearing occurs after a child is removed from their parent's home. At this hearing, a judge decides if it is safe for the child to return to and stay in the home.
- **The National Coalition for Child Protection Reform:** The National Coalition for Child Protection Reform (NCCPR) is an advocacy organization promoting public policy protecting children from abuse. It is a nonprofit organization dedicated to making the "child welfare" system better serve America's most vulnerable children.
- **Unfounded Status:** This status is assigned when an investigation concludes that insufficient evidence exists to substantiate alleged child maltreatment. The investigation findings do not support the claim of child abuse or neglect.
- **Yonas:** The pseudonym of the younger child in the Orion case.

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Attachments

ATTACHMENT 1 - CASE BRIEF ONE

ATTACHMENT 2 - CASE BRIEF TWO

ATTACHMENT 3 - CASE BRIEF THREE

ATTACHMENT 4 - CASE BRIEF FOUR

ATTACHMENT 5 - CASE BRIEF FIVE

ATTACHMENT 6 - CASE BRIEF SIX

ATTACHMENT 7 - LAWS OF CONFIDENTIALITY

ATTACHMENT 8 - QUALIFICATIONS OF JUVENILE COURT HEARING OFFICER

ATTACHMENT 9 - LETTER DETERMINING INDICATION OF CHILD ABUSE

ATTACHMENT 10 - LIKELIHOOD THAT TWO PARENTS HAVE MSBP

ATTACHMENT 11 - LIMITED SCIENCE ON MSBP

ATTACHMENT 12 - STATISTICAL REVIEW OF MSBP

ATTACHMENT 13 - STUDENT'S REVIEW OF MSBP

ATTACHMENT 14 - A FAMILY NARRATIVE

ATTACHMENT 15 - DECLARATIONS IN REGARDS TO INDICATIONS

ATTACHMENT 16 - PROCESS FLOW CHART

Attachment 1 - Case Brief One

The Controller's Office, charged with identifying and addressing waste, has received these documents from various sources. Please be advised that many of the documents contained within are confidential, as further delineated in the attachment "Laws of Confidentiality." Members of the public may request access to the specific information contained herein through a formal Right to Know request. Upon receipt of such a request, the county will undertake a comprehensive evaluation to determine whether the request complies with the criteria necessary to release the information.

Attachment 2 - Case Brief Two

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Attachment 3 - Case Brief Three

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Attachment 4 - Case Brief Four

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Attachment 5 - Case Brief Five

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Attachment 6 - Case Brief Six

The Controller's Office, charged with identifying and addressing waste, has received these documents from various sources. Please be advised that many of the documents contained within are confidential, as further delineated in the attachment "Laws of Confidentiality." Members of the public may request access to the specific information contained herein through a formal Right to Know request. Upon receipt of such a request, the county will undertake a comprehensive evaluation to determine whether the request complies with the criteria necessary to release the information.

Attachment 7 - Laws of Confidentiality

55 Pa. Code § Confidentiality (The Pennsylvania Code (2022
Edition))

§ 3490.242. Confidentiality

Information obtained by the county agency or Department in connection with general protective services may only be released as follows:

- (1) Under §3130.44 (relating to confidentiality of family case records).
- (2) To another county agency.
- (3) To an official of an agency of another state that performs general protective services analogous to those services performed by county agencies or the Department in the course of the official's duties.

History:

See the first section of this Title for historical and other information

55 Pa. Code § Confidentiality of family case records (The
Pennsylvania Code (2022 Edition))

§ 3130.44. Confidentiality of family case records

(a) Information that may be used to identify the child or the parents by name or address, and information contained in the case record, is confidential. A staff person may not disclose or make use of information concerning the child or the parents other than in the course of the performance of his duties.

(b) Federal authorities, the Commonwealth and the Department or respective authorized agents officially charged with administrative supervision, review, evaluation or audit responsibilities may have access to and the right to use information identifying applicants for and recipients of children and youth services. The information shall be necessary to carry out the mandated functions of the agency and may not be protected by a specific law, such as 23 Pa.C.S. §§ 6301-6384 (relating to the Child Protective Services Law).

(c) Members of the administrative review panels, volunteers, another county agency and other providers of services to children and families who are accepted for service by the county agency may have access to and the right to use information identifying recipients of children and youth services. The amount and type of information to be released shall be determined by the county agency and shall be limited to information needed by the service provider to carry out its responsibilities. The decision to release information shall be based on the county agency's assessment of the individual case record and the responsibilities of a service provider. Information released may include part or all of the case record.

(d) Information contained in case records shall be released upon request to:

(1) Parents and legal guardians.

(2) Children's and parents' attorneys.

(3) The court and court staff.

(4) County executive officers.

(5) The child, if 14 years of age or older. The county agency may withhold information from a child which it has reason to believe it will be harmful to the child. The basis for withholding information from a child shall be recorded in the child's case record.

(e) Information in case records may not be released to a person or agency other than those specified in subsections (b)-(d) without prior authorization of the court.

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55 Pa. Code § Confidentiality of family case records (The
Pennsylvania Code (2022 Edition))

(f) Information from a case record may be made available only if the information released does not contain material which violates the right to privacy of another individual or is protected or made confidential by law. This may not be construed to protect the right to privacy of a county agency employe.

(g) Except as limited by subsection (h), the county agency may use or authorize the use of information contained in the case records for teaching or research, if the teaching or research does not include names or other information which may directly or indirectly identify persons involved in the case. The county agency administrator shall approve or disapprove, in writing, requests from persons not employed by the county agency who wish to use agency case records for teaching or research purposes.

(h) To the extent that information contained in the family case record is protected by 23 Pa.C.S. Part III (relating to the Adoption Act), 23 Pa.C.S. §§ 6301-6384 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services), access to and release of information shall be under the statutes and regulations.

History:

See the first section of this Title for historical and other information

237 Pa. Code § Inspection of the Official Court Record
(Pennsylvania Juvenile Rules (2023 Edition))

RULE 1160. Inspection of the Official Court Record

The official court record is only open to inspection by:

- 1) The judges, officers, and professional staff of the court;
- 2) The parties to the proceeding and their counsel and representatives, but the persons in this category shall not be permitted to see reports revealing the names of confidential sources of information contained in social reports, except at the discretion of the court;
- 3) A public or private agency or institution providing supervision or having custody of the child under order of the court;
- 4) A court, its probation officers, other officials or professional staff and the attorney for the defendant for use in preparing a presentence report in a criminal case in which the defendant is convicted and who prior thereto had been a party to a proceeding under the Juvenile Act, 42 Pa.C.S. §6301et seq.;
- 5) The Administrative Office of Pennsylvania Courts;
- 6) The judges, officers and professional staff of courts of other jurisdictions when necessary for the discharge of their official duties;
- 7) Officials of the Department of Corrections, a State Correctional Institution or other penal institution to which an individual who was previously adjudicated delinquent in a proceeding under the Juvenile Act, 42 Pa.C.S. §6301et seq., has been committed, but the persons in this category shall not be permitted to see reports revealing the names of confidential sources of information contained in social reports, except at the discretion of the court;
- 8) A parole board, court or county probation official in considering an individual's parole or in exercising supervision over any individual who was previously adjudicated delinquent in a proceeding under the Juvenile Act, 42 Pa.C.S. §6301et seq., but the persons in this category shall not be permitted to see reports revealing the names of confidential sources of information contained in social reports, except at the discretion of the court.
- 9) The State Sexual Offenders Assessment Board for use in completing assessments; and
- 10) With leave of court, any other person or agency or institution having a legitimate interest in the proceedings or in the work of the unified judicial system.

**237 Pa. Code § Inspection of the Official Court Record
(Pennsylvania Juvenile Rules (2023 Edition))**

History:

The provisions of this Rule 1160 amended December 24, 2009, effective immediately, 40 Pa.B. 222.

Attachment 8 - Qualifications of Juvenile Court Hearing Officer

**237 Pa. Code § Qualifications of Juvenile Court Hearing
Officer (Pennsylvania Juvenile Rules (2023 Edition))**

RULE 1182. Qualifications of Juvenile Court Hearing Officer

A. Education, Experience, and Training. To preside as a juvenile court hearing officer over cases governed by the Juvenile Act, 42 Pa.C.S. §6301et seq., an individual shall:

- 1) be a member, in good standing, of the bar of this Commonwealth;
- 2) have been licensed to practice law for at least five consecutive years; and
- 3) have completed six hours of instruction, approved by the Pennsylvania Continuing Legal Education Board prior to hearing cases, which specifically addresses all of the following topics:
 - a) The Juvenile Act;
 - b) The Pennsylvania Rules of Juvenile Court Procedure;
 - c) The Child Protective Services Law;
 - d) evidence rules and methodology; and
 - e) child and adolescent development.

B. Continuing Education. Upon meeting the requirements of paragraph (A)(3), a juvenile court hearing officer shall thereafter complete six hours of instruction from a course(s) designed by the Office of Children and Families in the Courts, in juvenile dependency law, policy, or related social science research every two years.

C. Compliance.

- 1) A juvenile court hearing officer shall sign an affidavit attesting that he or she has met the requirements of this rule.
- 2) Prior to presiding as a juvenile court hearing officer, the attorney shall send the affidavit to the President Judge or his or her designee of each judicial district where the attorney is seeking to preside as a juvenile court hearing officer.
- 3) After submission of the initial affidavit pursuant to paragraph (C)(2), juvenile court hearing officers shall submit a new affidavit every two years attesting that the continuing education requirements of paragraph (B) have been met.

History:



**237 Pa. Code § Qualifications of Juvenile Court Hearing
Officer (Pennsylvania Juvenile Rules (2023 Edition))**

The provisions of this Rule 1182 adopted September 11, 2014, effective 10/1/2016, 44 Pa.B. 6087; amended July 13, 2015, effective 8/1/2017, 45 Pa.B. 3986; amended April 6, 2017, effective 9/1/2017, 47 Pa.B. 2313.

237 Pa. Code § Appointment to Cases (Pennsylvania Juvenile
Rules (2023 Edition))

RULE 1185. Appointment to Cases

A. *Appointment.* If necessary to assist the juvenile court judge, the president judge or his or her designee may appoint juvenile court hearing officers to hear designated dependency matters.

B. *Prohibited practice.* Juvenile court hearing officers shall not engage in practice before the juvenile court in the same judicial district where they preside over dependency matters.

History:

The provisions of this Rule 1185 amended April 6, 2017, effective 9/1/2017, 47 Pa.B. 2313.

237 Pa. Code § Authority of Juvenile Court Hearing Officer
(Pennsylvania Juvenile Rules (2023 Edition))

RULE 1187. Authority of Juvenile Court Hearing Officer

A. *No authority.* A juvenile court hearing officer shall not have the authority to:

- 1) preside over:
 - a) termination of parental rights hearings;
 - b) adoptions;
 - c) any hearing in which any party seeks to establish a permanency goal of adoption or change the permanency goal to adoption;
- 2) enter orders for emergency or protective custody pursuant to Rules 1200 and 1210;
- 3) issue warrants; and
- 4) issue contempt orders.

B. *Right to hearing before judge.*

- 1) Prior to the commencement of any proceeding, the juvenile court hearing officer shall inform all parties of the right to have the matter heard by a judge. If a party objects to having the matter heard by the juvenile court hearing officer, the case shall proceed before the judge.
- 2) If a party objects to having the matter heard by the juvenile court hearing officer pursuant to paragraph (B)(1), the juvenile court hearing officer or the court's designee for scheduling cases shall immediately schedule a hearing before the judge. The time requirements of these rules shall apply.

History:

The provisions of this Rule 1187 amended April 6, 2017, effective 9/1/2017, 47 Pa.B. 2313.

237 Pa. Code § Qualifications of Juvenile Court Hearing
Officer (Pennsylvania Juvenile Rules (2023 Edition))

RULE 1182. Qualifications of Juvenile Court Hearing Officer

A. Education, Experience, and Training. To preside as a juvenile court hearing officer over cases governed by the Juvenile Act, 42 Pa.C.S. §6301et seq., an individual shall:

- 1) be a member, in good standing, of the bar of this Commonwealth;
- 2) have been licensed to practice law for at least five consecutive years; and
- 3) have completed six hours of instruction, approved by the Pennsylvania Continuing Legal Education Board prior to hearing cases, which specifically addresses all of the following topics:
 - a) The Juvenile Act;
 - b) The Pennsylvania Rules of Juvenile Court Procedure;
 - c) The Child Protective Services Law;
 - d) evidence rules and methodology; and
 - e) child and adolescent development.

B. Continuing Education. Upon meeting the requirements of paragraph (A)(3), a juvenile court hearing officer shall thereafter complete six hours of instruction from a course(s) designed by the Office of Children and Families in the Courts, in juvenile dependency law, policy, or related social science research every two years.

C. Compliance.

- 1) A juvenile court hearing officer shall sign an affidavit attesting that he or she has met the requirements of this rule.
- 2) Prior to presiding as a juvenile court hearing officer, the attorney shall send the affidavit to the President Judge or his or her designee of each judicial district where the attorney is seeking to preside as a juvenile court hearing officer.
- 3) After submission of the initial affidavit pursuant to paragraph (C)(2), juvenile court hearing officers shall submit a new affidavit every two years attesting that the continuing education requirements of paragraph (B) have been met.

History:



**237 Pa. Code § Qualifications of Juvenile Court Hearing
Officer (Pennsylvania Juvenile Rules (2023 Edition))**

The provisions of this Rule 1182 adopted September 11, 2014, effective 10/1/2016, 44 Pa.B. 6087; amended July 13, 2015, effective 8/1/2017, 45 Pa.B. 3986; amended April 6, 2017, effective 9/1/2017, 47 Pa.B. 2313.

Attachment 9 - Letter Determining Indication of Child Abuse



Mailing Date: 7/25/2022

[REDACTED]
[REDACTED]
[REDACTED]

Child: [REDACTED]
Report Number: [REDACTED]
Status Determination: INDICATED
Investigating Agency: Lehigh

YOU ARE LISTED IN THE STATEWIDE DATABASE AS A PERPETRATOR IN AN INDICATED REPORT OF CHILD ABUSE.

An indicated report means that a county children and youth agency or the Pennsylvania Department of Human Services made a determination that you committed child abuse. As a perpetrator in an indicated report, you will probably be prevented from working in an organization serving children or a public or private school or from becoming a foster care or adoptive parent. As a perpetrator, you could also be prevented from volunteering in an organization serving children or public or private school or from obtaining certain educational degrees or certificates. Other volunteer and employment opportunities may also be negatively affected. A copy of the report of abuse is enclosed. Please read the report carefully.

If you disagree with the determination that you have committed child abuse and you want your name removed from the Statewide database, you have two options:

- (1) **You may appeal to the Department of Human Services and your appeal must be postmarked within 90 days of the mailing date listed at the top of this notice.**

To appeal you can use the enclosed form and check off the first box on the form. You may also write a letter requesting the appeal.

OR

- (2) **You have a right to a hearing now. You can skip the appeal described above and ask the Bureau of Hearings and Appeals for that hearing. This request must be postmarked within 90 days of the mailing date listed at the top of this notice.**

To ask for a hearing, you can use the enclosed form and check off the second box on the form. You may also write a letter requesting a hearing.

At the hearing, the children and youth agency or the Department of Human Services will be responsible for proving that there is substantial evidence to indicate the report.

Attachment 10 - Likelihood that Two Parents Have MSBP

TEXAS LUTHERAN UNIVERSITY

1000 West Court Street • Seguin, Texas 78155-5978

Dear Mr. Pinsley,

Per your question, I write here about the likelihood that two caregivers in the same household may both have Munchausen's syndrome by proxy (MSBP). I offer the following explanation of (*simple*) *probability* and *compound probability* and use the ends of the range of MSBP prevalence estimates provided by you to illustrate the example.

Formally you are asking a compound probability question. Compound probability is the product of two simple probabilities, and its calculation is based on the assumption that the two simple probabilities are unrelated, or independent.

The probability of a given event is equal to the ratio of events that satisfy a given outcome (e.g., a child being affected by MSBP) to the number of possible outcomes (i.e., 100,000). Formally, this is:

$$P(\text{Event}) = (\# \text{ of Events that Meet Criteria}) / (\text{Total Possible Events})$$

If the prevalence of MSBP is estimated to be from 0.5 to 2.0 per 100,000, the simple probability of one adult having MSBP would be a value from within the range of 0.5 to 2.0 divided by 100,000. Probability is always in the range from 0.0 to 1.0, inclusive. When multiplying two values below 1.0 the resulting value is lower.

Sometimes, as with a weather forecast, probability can be reframed as a *percent chance*. A given probability value may be multiplied by 100 to yield the percent chance of a given outcome. Therefore, multiplying the extremes of the probability range by 100 would yield an associated range of percent chances between 0% to 100%.

For the provided range of 0.5 to 2.0 cases per 100,000, to determine simple probability, one would need to pick a value for the number of events satisfying the criterion. Because your larger question concerns compound probability, I used the values from the two ends of the range to compound the conditions rather than interpolating the midpoint and using it twice, or arbitrarily picking two values within the range. The probabilities of the two extremes are as follows:

Set A = 0.5 cases out of 100,000.
and B = 2.0 cases out of 100,000.

Given the formula in the above paragraph,

and $P(A) = 0.5 / 100,000$, or 0.000005 (or $5.00\text{-E-}6$),
 $P(B) = 2.0 / 100,000$, or 0.00002 (or $1\text{E-}5$),

where P (sometimes framed as p , see further below) means probability. The probability values of A and B are effectively zero, but I provide the calculated values here in support of your need for a formal likelihood answer to the compound probability question. As *percentage* likelihood of each, one would have, the likelihood of:

and of $A = 0.0005\%$ chance,
 $B = 0.002\%$ chance.

Compound probability is the product of the probabilities of two independent events. Spouses arguably do not meet the criteria for being considered independent, and the real probability of both spouses having MSBP may well be higher (i.e., when both spouses are tolerant of child abuse the couple may be more likely to remain together in comparison to situations with spouses having opposing tolerances of child abuse), though it is impossible to estimate how much higher.

The following argument ignores the potential violation of the assumption of independence when calculating compound probability. To calculate the compound probability of two individuals (e.g., spouses in a household), one would determine individually the probability of each parent having MSBP in a household and multiply the two probabilities.

Extending the example from above, the formal framing of the question is.

or $P(A \text{ and } B) = P(A) * P(B)$
 $P(A \text{ and } B) = 0.000005 * 0.00002 = 0.000000001$ (or $1.00\text{E-}10$)

Phrased as a *percentage* likelihood,

the likelihood of A and B is 0.00000001% chance (or $1.00\text{E-}08\%$).

Whether framing the likelihood as probability or percent likelihood, the obvious conclusion is that the likelihood of two caregivers in the same house having MSBP is miniscule. The odds are very rare.

Most statisticians would *not* report the analysis if the assumption of independence were violated. In the case of an inferential statistic with an alternative nonparametric analog, the nonparametric tool would be used. With probability estimates, there is not an appropriate non-parametric alternative.

Notwithstanding the potential violation of independence, it may be instructive to consider a 'penalty' to facilitate framing the estimated prevalence in accessible language. Skeptics of the following approach are encouraged to present an alternative for determining the rarity of a probability that is potentially quasi- or even demonstrably related. The objective of the question

at hand is to contextualize the chance of MSBP for two adults in the same house. Statistical tools are blunt instruments, and the accessibility of percent likelihood estimates may be useful in simplifying expressions of complex information.

Consider calculating the compound probability of two events of unknown independence. To create a fairer understanding of the compound probability of two potentially related events, would it be appropriate to multiply the products of the simple probabilities of each by a (penalizing) value to make the likelihood estimate more cautious? Perhaps. Note that using a multiplier above 1.0 would make the resulting value appear less rare.

In other words, when two probability values are potentially related, is there a 'conservative' multiplier that would make the resulting value a better guess at the compound likelihood value? For example, would multiplying a given compound likelihood by 1,000 or 1,000,000 (1M) adjust sufficiently for the potential relatedness of the two probability estimates?

If one were to multiply the percent chance by 1,000 (i.e., adjust the value to be as if the compound probability is 1,000 times more likely among spouses than adults living apart), one would still yield a ridiculously low value of 0.00001% chance (or 1.00E-05%) of two caregivers in the same household having MSBP. Extending the increased likelihood multiplier to 1M to account for the likely independence violation, one would still end up with only a 0.01% chance (or 1.00E-02%).

There is no real solution for resolving the violation of the assumption of independence. I offer the 1M multiplier to facilitate returning an accessible percent chance.

(Note: Below, I return to framing this as a probability value rather than percent chance for the following example.)

Pushing the multiplier to 500,000,000 (1/2B) results in a probability for the compound outcome of 0.05. That is,

$$P(A)*P(B)*(500,000,000) = 0.05 = p.$$

The widely agreed upon threshold for rejecting a (null) hypothesis in frequentist statistics is 0.05. In other words, probability values at or below 0.05, that is, $p \leq 0.05$, are considered statistically rare (I am avoiding cluttering this argument with concerns about 1- vs 2-tailed hypothesis testing). Combining information from above, if one could resolve the violation of independence assumption problem for determining the compound probability of two particular people having MSBP by multiplying the initial value by 1/2 Billion, the resulting value would still be considered statistically rare.

In frequentist modeling, when a test statistic is significant one rejects the null hypothesis in favor of a rival explanation. Based on the supposition that multiplying a compound probability value by 1/2B is a reasonable way to resolve the potential violation of independence assumption, the coincidence of two particular people (e.g., both parents in one house) having MSBP still meets the criterion for being statistically significant (i.e., rare).

Statistics is not a precise discipline, and we are working with wild estimates, and yet it appears that the probability remains infinitesimally small that two caregivers in the same household would have MSBP. There is no convention for transforming compound probabilities when there may be a defensible argument that the events are related.

Colloquially, after being penalized with the multiplier of $1/2B$ presented herein to adjust for the potential relatedness of the probabilities at issue, oddsmakers would be flummoxed and the over/under would be nil. If weather forecasters presented such an unlikely chance of rain, cars would get washed, windows would be left open, gardeners would worry about their plants, and firefighters would be on the ready. The lifetime odds of one person's death by all preventable causes would be lower than the chance of two caretakers having MSBP (see the National Safety Council at <https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/>). The preponderance of MSBP cases in NE Pennsylvania suggests either regional social contagion of MSBP or widespread misdiagnosis of the disorder.

Best Regards,
Scott A. Bailey

Scott A. Bailey, Ph.D.
Chair and Professor of Psychology
Integrated Science Program Director
Honors Program Director
Texas Lutheran University
Seguin, Texas 78155
E: SBailey@TLU.edu

Attachment 11 - Limited Science on MSBP



THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

VAN HECKE-WETZEL HALL
CAMPUS BOX 3330
CHAPEL HILL, NC 27597-3330

T 919.962.1706
F 919.962.1277
www.law.unc.edu

Mark Pinsley,
Controller
Lehigh County Controllers Office
17 South Seventh Street
Room 465
Allentown, PA. 18101-2400

August 15, 2023

Dear Mr. Pinsley,

As I have told you, it is generally agreed that the scientific research on the issue of the behavior known since the 1970s as "Munchausen's Syndrome by Proxy" (MSBP) has identified no distinct underlying psychopathology associated with this behavior. Although the American Psychiatric Association recognized the behavior of "factitious disorder imposed on another" (FDIA) as a diagnosis in 2013, they did not do so based on scientific knowledge that identified such a specific psychopathology. Further, no adequate science has validated the reliability of any particular set of standards for diagnosing MSBP/FDIA as a psychological disorder, as Eric Mart's and Loren Pankratz's work have amply demonstrated.

Even were it possible for physicians or mental health professionals to reliably diagnose MSBP, the chances that such a disorder would occur independently in two parents in the same household would be exceedingly slight. The incidence rates most often cited for MSBP/FDIA behavior are 2 in 100,000 children. Assuming that the disorder developed independently in each parent, that would put the chances of two parents developing the disorder in the same household at 1 in 2,500,000,000 children. Given there are only roughly 74,000,000 children in the entire United States, we would expect this to occur in a U.S. family rarely indeed.

Again as I have told you, and as I describe in several articles, the behavior that physicians sometimes call MSBP today is actually identified based on a far broader definition and set of standards than the behavior earlier identified by that terminology. In recent years, pediatricians and others have begun to diagnose a broad category of parental behavior they believe is associated with the overmedicalization of children that they call "Medical Child Abuse" (MCA). While they sometimes say that MCA is synonymous with MSBP, a determination that MCA has occurred does not require the intent associated with MSBP/FDIA or with child abuse, and it falls short of meeting other standards for child abuse, as well. To the extent that physicians or mental health professionals determined in a particular case that MCA behavior occurred for which both parents were responsible, that should not properly be equated with either a diagnosis of MSBP/FDIA or with a determination that child abuse, as defined by legal standards, has occurred.

I am happy to answer any other questions you may have on this issue.

Sincerely,

A handwritten signature in black ink that reads "Maxine Eichner". The signature is written in a cursive style with a small flourish at the end.

Maxine Eichner
Graham Kenan Distinguished Professor of Law
UNC School of Law

Attachment 12 - Statistical Review of MSBP

TEXAS LUTHERAN UNIVERSITY

1000 West Court Street • Seguin, Texas 78155-5978

August 3, 2023

Mr. Mark Pinsley
Lehigh County Controller
Lehigh County Government Center
17 South Seventh Street
Allentown, PA 18101

Dear Mr. Pinsley:

This report was written in response to your request for analyses of data provided by you concerning the prevalence of Munchausen Syndrome by Proxy (MSBP) in different regions of the state of Pennsylvania (Central, Northeast, Southeast, Western). MSBP is a particular form of child abuse wherein a parent or guardian of a child presents false symptoms of her/his child to medical professionals and the public.

Please note the following to contextualize this report:

- 1) I used the data as provided by you/your office and did not verify it independently.
- 2) The provided data were limited to Pennsylvania, and as such did not permit analyses comparing target regions to, for example, other demographically similar regions of the country outside of Pennsylvania. It is understood the diagnosis of MSBP is itself questionable, and therefore prevalence estimates are likely in error. Notwithstanding the particulars of this report, typically one anticipates that random error applies equally to all regions. When a region stands out in comparison to other regions, the difference is attributed to signal rising above measurement noise, suggesting a nonrandom pattern may be at issue. Nonrandom patterns may be indicative of one or more discernable, systematic influences on the targeted dependent variable.
- 3) I am a neuroscientist by training, not a clinical psychologist, and am not expert in MSBP. I am, however, aware of MSBP from having learned about it in graduate school, as well as having studied it anew in association with this contracted work.
- 4) Although I am not a clinical psychologist, I am competent to perform statistical analyses based on graduate training and a 29-year career during which I have taught quantitative methods to undergraduate students and performed a host of analyses on original data.
- 5) Although I performed several analyses that may have been reported for these data, I offer below two varieties (frequentist and Bayesian) of χ^2 (Chi Square) for goodness of fit. Chi

Square is a nonparametric test that is taught in first courses in undergraduate-level statistics courses and is as accessible a model for inferential analysis as is available. Specifically, Chi Square modeling assumes that occurrences of data should be random—i.e., evenly distributed across measurement bins, such as counties or regions in the case at hand—unless otherwise specified, and tests whether deviations from expected occurrences are rare under conditions of the null hypothesis (H_0). Significant deviation from equality suggests that H_0 is wrong and leads to rejection of the null hypothesis in frequentist statistics. When rejecting the H_0 in frequentist modeling, the implication is that an alternative hypothesis, H_A , explains the data better. Note that in frequentist modeling there is never direct testing of the alternative hypothesis; rejection of the null is marshalled as *indirect evidence* in support of an/the alternative hypothesis. Bayesian modeling involves estimation of population parameters based on Bayes' Theorem, an idea first set forth by an 18th century English mathematician and made possible today by the power of modern computing. Bayesian modeling is a feature of the statistics software, JASP (JASP Team, 2023), which was used for the analyses presented in this report. JASP is a graphic user interface that relies on the R statistical analysis 'back-end' programming environment to generate results. The advantage of Bayesian modeling is that it *tests H_A directly* in thousands of reiterative (Monte Carlo) analyses, thereby giving more direct support of rival explanations of data versus merely rejecting H_0 . A feature of Bayesian modeling in JASP is that the software returns a Bayes Factor that is a rough indicator of whether, and if so, how much more likely the alternative hypothesis is than the null given the data.

- 6) Nothing can be proven in science. Statistical modeling involves using sample data to make inferences about possible population-level trends.

Results. A frequentist (aka, Classical) analysis comparing the numbers of MSBP cases from the four regions of Pennsylvania, collapsed across the six years (2016 – 2021) for which data were available, revealed a significant effect. $\chi^2(3) = 15.84$, $p < 0.05$, indicating *nonrandomly distributed* prevalences of 25 MSBP cases in the four regions of Pennsylvania. In order from highest to lowest, the Northeast region had the most cases (10, 40% of the total for the state), while the most populous Southeast region had seven (28%), and the Central and Western regions each had four (16%) cases for the six-year date span. The Chi Square model assumed equal distribution of cases across the regions, or 6.25 cases per region (25% per each). The Northeast region of Pennsylvania had 1.6 times the anticipated prevalence ($1.6 \times 6.25 = 10$) for the six-year date span.

The Bayesian χ^2 analysis revealed a Bayes Factor of 10.609 ($BF_{10} = 10.609$, where the subscript ₁₀ means alternative hypothesis ₍₁₎ compared to the null hypothesis ₍₀₎). Mulder & Wagenmakers (2016) are champions of Bayesian modeling and offer interpretative guidelines for BF values (Wagenmakers has been a chief developer of JASP, and adapted guidelines based on a 1961 paper by Sir Harold Jeffereys). Per Jeffereys via Mulder & Wagenmakers, $BF_{10} = 10.609$ means the data are 10+ times more likely under conditions of the alternative hypothesis than under the null. Echoing Jeffereys, Mulder & Wagenmakers categorize $BF = 10$ as *strong evidence* for the alternative hypothesis in favor of the null in accounting for the data.

Summary of Results. The frequentist χ^2 revealed a significant effect for the MSBP data, indicating that the null hypothesis of statistical equality across the four regions of Pennsylvania must be *rejected*. The Bayesian χ^2 suggests that the MSBP data are approximately 10 times more likely under conditions of the alternative hypothesis than the null, and by extension suggesting that the Northeast region outpaces the other three regions significantly for the six-year date span in question. Please note that the BF is a reference to the value of the alternative hypothesis in explaining the data as compared to the null hypothesis; it does *not* mean that the Northeast region has 10 times the cases—rather, the Northeast region

has 1.6 times the prevalence of MSBP that one would expect if the cases were randomly (i.e., evenly) distributed across the regions. Finally, note that χ^2 uses proportions for calculations rather than raw values, thereby adjusting for population density disparities across the regions.

Interpretation. MSBP is rare with relatively low numbers occurring at the county level, and analyses of the county-level data failed to discern statistically significant differences despite the glaring absolute values for Northampton County; county-level signals did not overcome the noise among them to reveal a significant effect. The above analyses were thus performed and reported at the regional rather than at the county level. Amalgamating the counties into the four respective regions revealed that the Northeastern region accounts for 40% of the cases in the state (i.e., 10 of 25 cases were from the Northeast region). Nearly a quarter of the cases (6 of 25, or 24%) in the state were from Northampton County, a county in the Northeastern region of the state. Clearly something happening in Northampton County drove the prevalence of MSBP diagnosis enough to violate the expectation of even distribution of cases, which in turn led to the large number of cases in the Northeast region.

Given the seriousness of child abuse and the rarity of Amnchausen Syndrome by Proxy, close examination into what is driving the high number of diagnoses in the Northeast region generally, and Northampton County specifically, appears not only merited but urgent.

Sincerely,
Scott A. Bailey

Scott A. Bailey, Ph.D.
Chair and Professor of Psychology
Integrated Science Program Director
Honors Program Director
Texas Lutheran University
Seguin, Texas 78155

References

- JASP Team (2023). JASP (Version 0.17.3)[Computer software].
- Mulder, J., & Wagenmakers, E.-J. (2016). Editors' introduction to the special issue "Bayes factors for testing hypotheses in psychological research: Practical relevance and new developments". *Journal of Mathematical Psychology*, 72, 1-5. <https://doi.org/10.1016/j.jmp.2016.01.002>

Attachment 13 - Student's Review of MSBP

Unusual Pattern of Munchausen's by Proxy Cases in Northampton County, Pennsylvania

Introduction:

This report examines the occurrence of Munchausen's Syndrome by Proxy (MSBP) cases in Northampton County, Pennsylvania, and highlights the significant deviation from the national average. The data suggests the presence of influencing factors as recent reports of MSBP are significantly higher than expected in this region. Further investigation into the validity of these reports is recommended.

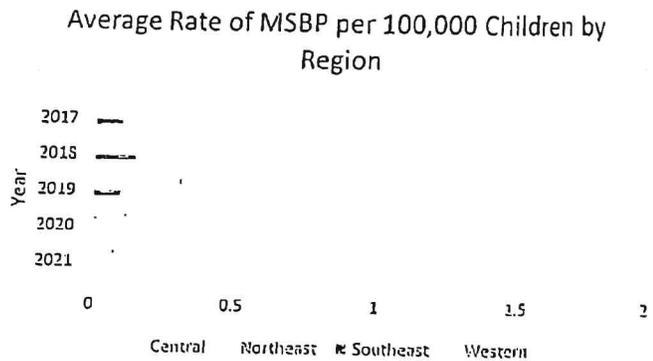
Background:

Munchausen's by Proxy (MSBP) is a rare and severe form of child abuse, primarily perpetrated by a caregiver, often the mother, who deliberately fabricates or induces illness in a child in order to assume a caring parental role (Eichner, 2016). The diagnosis of MSBP emerged in the 1980s when physicians in the United States and the United Kingdom began identifying and studying such cases. However, the term MSBP sparked controversy and presented several challenges. Although Meadow, the originator of the syndrome, did not intend to imply a diagnosable psychological condition in mothers, MSBP came to be widely perceived as such. This led to debates about its classification as a psychological disorder, disagreements on defining its elements, and the question of whether the diagnosis should be assigned to the parent or the child. Pediatricians, who often identified these behaviours, faced difficulties in diagnosing the mental health of the parent (Pankratz, 2010).

Moreover, the diagnostic criteria for MSBP were overly broad, resulting in false identification of parents whose children were genuinely ill. In England, the credibility of MSBP diagnoses declined following high-profile cases where children initially believed to have died from MSBP were later found to have authentic illnesses. This led to a loss of confidence in the MSBP diagnosis and raised doubts about the authority of involved experts (Eichner, 2016). Despite these controversies, pediatricians in the United States remained committed to addressing problematic parental behaviour and introduced the concept of medical child abuse as a response (Eichner, 2016).

The prevalence rate of MSBP remains largely unknown, but studies conducted in the British Isles estimate an annual incidence of 0.5/100,000 for children under 16 years. Another study suggests a similar incidence rates of 0.4/100,000 among children below 16 years and 2-2.8/100,000 among children below one year. With this information an estimated incidence of 0.7/100,000 for children under 16 years old was calculated assuming equal age distribution. Considering that the United States quantifies children as individuals under the age of 18 years old and that MSBP is primarily reported in young children under one year old, it can be expected that the rate would be slightly lower when including children between 16-18 years old. That said, no prevalence studies have been conducted in the USA. Other reports indicate a broad annual incidence of 0.5-2.0/100,000 for children under 18, which is the range used for all following analysis (Cömert, 2018).

In the following figure, it can be observed that each county in Pennsylvania falls within the expected bounds of the national average. Notably, in 2019, the Northeast region reported an MSBP rate nearly three times higher than every other region, indicating a significant deviation.

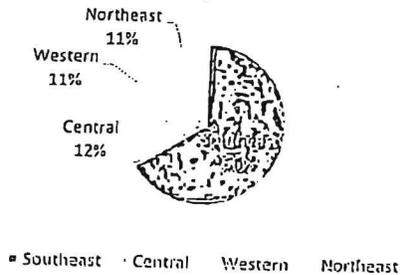


Statewide Overview

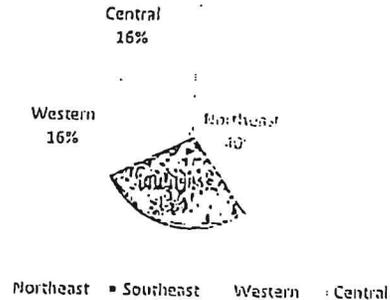
Between 2017 and 2021, Pennsylvania consistently reported an average of 5 MSBP cases per year. With the state's average child population reaching approximately 2.74 million, the anticipated range of MSBP cases would fall between 13 and 54 cases per year based the incidence rate of 0.5-2.0/100,000 for children under 18 years old. The reported state average of 5 cases per year, while lower than expected, is not quantified as an outlier. Out of the total 67 counties in Pennsylvania, only 10 counties reported cases of MSBP during this period. Interestingly, only 5 of the 10 counties reported more than a single case of MSBP, and merely 2 counties reported more than 3 cases, signifying a concentrated occurrence of MSBP within a limited number of counties.

County	Total MSBP Cases from 2017-2021	Max MSBP Cases a Single Year	Max Rate of MSBP Cases per 100,000 Children
CARBON	1	1	7.99
CUMBERLAND	2	1	1.993
ERIE	3	2	3.395
FRANKLIN	1	1	2.889
LEHIGH	2	2	2.416
NORTHAMPTON	6	3	4.945
NORTHUMBERLAND	1	1	5.483
PHILADELPHIA	7	3	0.868
TIOGA	1	1	12.174
WARREN	1	1	13.05
Grand Total	25	3	13.05

Average Child Population by Region



Total MSBP Cases by Region



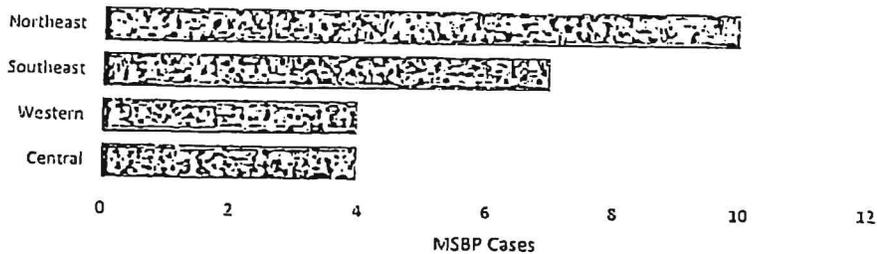
Northeast Region of Pennsylvania:

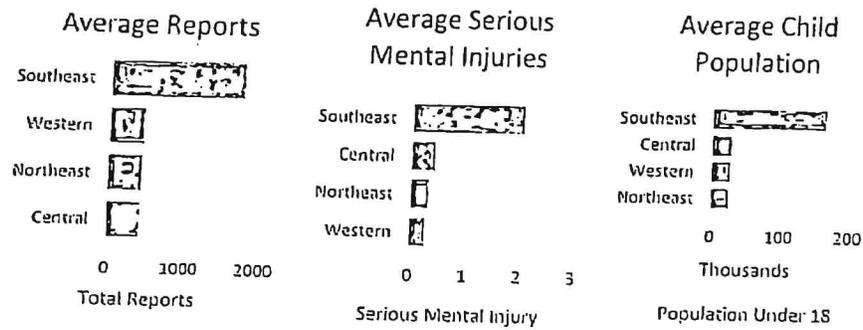
The Northeast Region of Pennsylvania consists of 14 counties with the most noteworthy being Northampton and Lehigh. This region accounts for 40% of the total reported MSBP cases, the highest in the state, yet it also has the smallest child population of approximately 27,000 children which represents only 11% of the total child population in the state. Additionally, the Northeast Region has comparatively fewer annual child abuse cases, approximately 39,000 cases, accounting for 17% of the total abuse cases in the state. It also has fewer reports of serious mental injuries to children, with only 24 cases, representing 14% of the total mental injury reports in the state.

Despite the Northeast region having few child abuse reports (which includes MSBP cases), few mental injury cases, as well as the lowest child population of all the regions in Pennsylvania, it demonstrates the highest number of MSBP cases compared to any other region in the state. With a total of 10 MSBP cases, it comprises 40% of the state's total MSBP cases. In comparison, the Southeast region with the next highest number of cases reports 7 MSBP cases, representing 28% of the state's total cases. Notably, the Southeast region includes Philadelphia, one of the largest cities in Pennsylvania.

Overall, these findings emphasize the disproportionate concentration of MSBP cases in the Northeast Region, despite its smaller child population and relatively fewer reports of child abuse and mental injuries in children.

Total MSBP Cases by Region





Northampton County Outliers:

Among the 14 counties in the Northeast Region, the presence of MSBP cases is relatively limited, with only 4 of the 14 counties reporting MSBP cases between 2017 and 2021. It is particularly noteworthy that Northampton County and Lehigh County accounted for 8 out of the 10 total reported cases in the Northeast Region. This represents approximately 32% of all MSBP cases reported in Pennsylvania between 2017 and 2021, despite Northampton and Lehigh County having a combined population of less than half that of Philadelphia, the largest county in Pennsylvania.

The striking nature of this observation becomes even more apparent when considering Northampton County's child population of only 60,000. Northampton has an estimated rate of 4.9 MSBP cases per 100,000 children, which significantly exceeds the national average maximum of 2 cases per 100,000 children, surpassing it by more than double. Furthermore, when applying the outlier Inter Quartile Range (IQR) formula, known as the 1.5 IQR rule, Northampton County falls above the expected threshold in both 2019 and 2021, with a rate of 4.945 cases per 100,000 children and 3 reported cases each year. The national estimated maximum 1.5 IQR is 2.75 cases, indicating that Northampton County's numbers are notably elevated.

The consistency of the outlier status over two consecutive years, coupled with the shared hospital between Lehigh and Northampton counties and the absence of reports in Northampton County coinciding with Lehigh County's first two consecutive cases of MSBP, suggests that these findings are unlikely to be random occurrences. The statistical significance of the outlier further supports the notion that these are abnormal conditions rather than natural variations within the standard deviation.

When comparing Northampton County with the remaining 66 other counties in Pennsylvania, it becomes even more evident that it exceeds the expected values for both the range and 1.5 IQR. However, due to the relatively small sample size of 25 collected data points, no correlation could be established. This is substantiated by the ANOVA, X^2 (Chi-Square), and sample correlation coefficient, all of which exceed the required significance level.

To better visualize the data, the bar chart below depicts the rate of MSBP when counties with no cases or those with only a single case of MSBP from 2017-2021 are removed. Notably, Northampton County emerges as the most significant outlier when counties with only a single case of MSBP are removed from consideration.

Attachment 14 - A Family Narrative

The Controller's Office, charged with identifying and addressing waste, has received these documents from various sources. Please be advised that many of the documents contained within are confidential, as further delineated in the attachment "Laws of Confidentiality." Members of the public may request access to the specific information contained herein through a formal Right to Know request. Upon receipt of such a request, the county will undertake a comprehensive evaluation to determine whether the request complies with the criteria necessary to release the information.

Attachment 15 - Declarations in Regards to Indications

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Attachment 16 - Process Flow Chart

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