

# CHILDREN'S RIGHTS LITIGATION

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ARTICLES

## Handling Child Abuse Cases Involving Violent Shaking and Abusive Head Trauma

By P. Leigh Bishop, William H. Branigan, John M. Leventhal, and Mark A. Mittler – June 18, 2015

Violent shaking and similar abuse, such as slamming, stomping, and punching a child's head, known collectively as abusive head trauma (AHT), kill or seriously injure hundreds of children in the United States every year. And—as is well settled in the scientific community—violent shaking alone can seriously injure or kill a child. There is also broad scientific consensus that the resulting injuries, known as shaken baby syndrome (SBS), are strong evidence of abuse. Therefore, it is important that, upon diagnosing children with head injury, the medical community work with law enforcement and social services to identify cases of abuse, protect the victims, and, when necessary, prosecute the offenders.

Most major children's hospitals in the United States have doctors from various disciplines who can diagnose and treat children with severe head trauma, and determine whether those children have been abused. After a hospital reports suspected child abuse to the authorities, law enforcement and social services must make their own determinations of whether abuse has occurred, whether to remove the child from his or her home, and whether to prosecute someone for child abuse. These decisions can destroy families and confine someone to prison, but are necessary to protect the lives of vulnerable children. Therefore, child abuse professionals must investigate these cases thoroughly to make informed and accurate findings. As discussed below, by consulting with treating physicians and by conducting a proper investigation, prosecutors, child welfare attorneys, police officers, and social workers can protect children while minimizing the possibility of wrongful convictions and wrongly broken homes.

### AHT/SBS Diagnosis Is Well Established in the Scientific Community

The AHT/SBS diagnosis is well supported in the medical literature. Indeed, decades of studies support the conclusion that violent shaking can seriously injure or kill a child, that trained physicians can diagnose this abuse, and that, every year, hundreds of children suffer serious injuries from violent shaking. The American Academy of Pediatrics and other reviews have highlighted the key findings in children with abusive head trauma. *See* Cindy W. Christian et al., "[Abusive Head Trauma in Infants and Children](#)," 123 *Pediatrics* 1409 (2009); John M. Leventhal et al., "Diagnosing Abusive Head Trauma: The Challenges Faced by Clinicians," 44 (Supp. 4) *Pediatric Radiology* S537 (2014). Studies, including those from the Centers for Disease Control and Prevention (CDC), have examined the incidence of AHT/SBS. *See* Sharyn Parks et al., "[Characteristics of Non-Fatal Abusive Head Trauma among Children in the USA, 2003–2008: Application of the CDC Operational Case Definition to National Hospital Inpatient Data](#)," 18 *Inj. Prevention* 392 (2012). Other studies have focused on distinguishing abusive from accidental head injuries. *See* Mary E. Case, "Distinguishing Accidental from Inflicted Head Trauma at Autopsy," 44 (Supp. 4) *Pediatric Radiology* S632 (2014). And still others have described the confessions of adult perpetrators of AHT/SBS. *See* Dean Biron & Doug Shelton,

[“Perpetrator Accounts in Infant Abusive Head Trauma Brought About by a Shaking Event,”](#) 29 *Child Abuse & Neglect* 1347 (2005); Suzanne P. Starling et al., [“Analysis of Perpetrator Admissions to Inflicted Traumatic Brain Injury in Children,”](#) 158 *Archives Pediatrics & Adolescent Med.* 454 (2004); Matthieu Vinchon et al., “Confessed Abuse versus Witnessed Accident in Infants: Comparison of Clinical, Radiological, and Ophthalmological Data in Corroborated Cases,” 26 *Child's Nervous Sys.* 637 (2010).

In the United States, medical school curriculums include the problem of child abuse. In addition, most major medical centers in the United States have at least one pediatrician who is board certified in child abuse pediatrics and who has experience both in diagnosing AHT/SBS, and, as important, in excluding AHT/SBS in children with head injuries. Indeed, doctors in major medical centers are well trained in diagnosing AHT/SBS and in detecting other potential causes for the injuries and findings associated with AHT/SBS.

Medical science has demonstrated that violent shaking can cause a spectrum of injuries to a child's head, ranging from mild to fatal. These injuries include brain damage, subdural hemorrhage (bleeding between the brain and skull), retinal hemorrhage (bleeding inside the eye), and neck and spinal cord injury. See Gil Binenbaum & Brian J. Forbes, “The Eye in Child Abuse: Key Points on Retinal Hemorrhages and Abusive Head Trauma,” 44 (Supp. 4) *Pediatric Radiology* S571 (2014); Mark P. Breazzano et al., [“Clinicopathological Findings in Abusive Head Trauma: Analysis of 110 Infant Autopsy Eyes,”](#) 158 *Am. J. Ophthalmology* 1146 (2014); Alison Kemp et al., “Spinal Injuries in Abusive Head Trauma: Patterns and Recommendations,” 44 (Supp. 4) *Pediatric Radiology* S604 (2014). In addition, these children often have bruises and fractures to other parts of their bodies. Ignasi Barber & Paul K. Kleinman, “Imaging of Skeletal Injuries Associated with Abusive Head Trauma,” 44 (Supp. 4) *Pediatric Radiology* S613 (2014). And shaking alone, without impact, can cause death. James R. Gill et al., “Fatal Head Injury in Children Younger Than 2 Years in New York City and an Overview of the Shaken Baby Syndrome,” 133 *Archives Pathology & Laboratory Med.* 619 (2009). Thus, there is broad scientific consensus that, when trained doctors diagnose these injuries in a child—and exclude other possible causes for the injuries—they can conclude to a reasonable degree of medical certainty that the child has been abused.

### **Child Abuse Doctors Can Diagnose Abuse in a Child with Severe Head Injury**

Law enforcement officials and social workers charged with investigating a case of suspected AHT/SBS should consult with medical doctors, especially those who have treated the injured child, to determine whether abuse has occurred. Major children's hospitals often have child abuse pediatricians, pediatric neurosurgeons, pediatric neurologists, pediatric ophthalmologists, pediatric orthopedists, pediatric intensive care unit specialists, pediatric hematologists, and pediatric radiologists and neuroradiologists who evaluate and treat children with symptoms of head injury. Working together, these specialists are well positioned to diagnose abuse and exclude other causes for a child's head injuries.

Typically, working as a group, these medical specialists develop a working “differential diagnosis” to systematically and thoroughly consider all reasonable possibilities for the child’s injuries. While certain findings—including subdural hemorrhage, retinal hemorrhage, and cerebral swelling—are strong evidence of inflicted head trauma in a child, other possibilities must be considered. Therefore, experienced doctors generally rule out accidents and medical causes such as bleeding disorders, metabolic problems, and infections.

In addition to medical tests, the treating doctors should review the injured child’s medical history—including birth records and well child and illness visits—to understand the child’s development and physical capabilities, to identify significant health problems, and to consider the possibility of a traumatic birth or other noninflicted trauma. Similarly, in cases where a child dies from head injuries, a thorough autopsy, including evaluation of the child’s brain and eyes, is needed. M.G.F. Gilliland et al., “Guidelines for Postmortem Protocol for Ocular Investigation of Sudden Unexplained Infant Death and Suspected Physical Child Abuse,” 28 *Am. J. Forensic Med. & Pathology* 323 (2007).

Physicians who care for children with head trauma can use their clinical experience to distinguish accidental from inflicted injury. These doctors frequently encounter injuries in children that are clearly accidental—for instance, where children have been hit by cars, have fallen off bicycles, or have been struck by baseballs. In these cases, they know the cause of injury, in part, because there is a witness. In other cases where an infant or young child has suffered a serious head injury, caregivers bring the child to the hospital without information about how the injury occurred or claim that an accident caused the injury. In these cases, pediatric specialists may use their experience to determine whether the caregiver’s history can explain the child’s injury. See Carole Jenny, “Alternate Theories of Causation in Abusive Head Trauma: What the Science Tells Us,” 44 (Supp. 4) *Pediatric Radiology* S543 (2014).

For instance, a 10-month-old child might appear at the hospital with no external signs of trauma, but massive hemorrhage around the brain and in the eyes. Should a parent claim that the child fell from a standing position within a crib against the side rail and onto a mattress, pediatric specialists could evaluate whether this history was consistent with the injury.

### **Child Abuse Professionals Must Still Conduct Their Own Careful Investigation**

Police officers, lawyers, and social workers assigned cases involving possible AHT/SBS must conduct their own careful and thorough investigations, even after treating physicians have determined that abuse has occurred. Investigators should approach cases of potential child abuse with an open mind, consider all relevant surrounding circumstances, and follow the evidence without bias toward any particular outcome. There are concrete steps, however, that an agency official or attorney can take to investigate suspected AHT/SBS fairly and accurately.

First, investigators must understand the child’s condition and diagnosis and determine whether the child suffered abuse. Therefore, they should consult with the treating physicians about their diagnosis and discuss all of the issues noted above.

Second, investigators should collect the child's relevant medical records and review them with a reputable, practicing pediatric physician. A physician can translate confusing medical documents and explain how the documents might support or undermine a finding of abuse. For instance, a physician could tell from the records whether the child had a preexisting condition and whether that condition might have contributed to the child's injuries. And a physician could explain any tests that were performed and how those tests might eliminate different medical conditions as causes of the injury.

Third, after determining that the child has been abused, investigators must determine who committed the abuse. They should begin by finding who had access to the child when he or she suffered the injury, because, when inflicted head trauma causes death or serious injury, the child's deterioration is usually immediate and obvious. The symptoms of inflicted trauma include lethargy, limpness, difficulty breathing, seizures, unresponsiveness, coma, and death. Therefore, in these circumstances, the investigator should consider who was with the child when the symptoms manifested.

Law enforcement officials should develop a thorough and detailed timeline for at least 48 hours before the child's hospital admission. The timeline should include all of the child's regular activities such as eating, sleeping, and playing, and it should note who was with the child through this time period. Investigators should also document any "stressors" that might trigger a person to commit violence against a child. Many factors can stress a caregiver, including the victim child's inconsolable crying, general frustration, and fighting within the household.

Confessions and admissions also can prove the identity of the abuser. In some cases, the perpetrator will confess to shaking or otherwise abusing the child to the treating physicians at the hospital. In other cases, an abuser might confess to law enforcement or a social worker during an interview. As in every criminal case, the investigator must ensure that this confession is free and voluntary. In addition, investigators should get as much detail as possible about the abusive conduct without leading the suspect into particular answers.

The suspect's statements should be as detailed as possible. If the suspect is innocent, details might allow an exculpatory statement to be corroborated with further investigation. Details also can open further avenues of investigation. In addition, a detailed confession might explain a perpetrator's motive and how the abuse occurred. Indeed, when abusers confess, they might describe how—and with how much force—they abused the child and how the child reacted to the abuse. They might also explain why they abused the child.

In the absence of a full confession, a detailed statement can be useful in deciding whether to arrest and prosecute the suspect or remove a child from his or her home. A suspect might place himself or herself with the child, make demonstrably untrue statements, or offer other information that is inculpatory. For instance, a father's claim that "the baby rolled off the couch," where his child has suffered multiple rib fractures, a skull fracture, brain swelling, and bilateral

retinal hemorrhages, might be demonstrably untrue and, depending on the circumstances, might be evidence of a guilty mind. In other cases, the investigator might corroborate the suspect's story and exclude him or her as the perpetrator.

Thus, while there is no single, precise formula for an accurate and thorough investigation, there are basic steps that every investigator should take. And by following these steps and working with medical doctors, child abuse professionals can be confident when deciding to prosecute an offender or remove a child from a home.

### **Be Prepared to Respond to Defenses, Including Flawed Diagnosis**

Child abuse professionals, especially prosecutors and lawyers providing services to children, should be prepared to confront a variety of defenses in court, including claims that a child's injuries resulted from a disease or accident, and even claims that AHT/SBS is not a valid diagnosis. When faced with a claim that the treating physician overlooked a particular cause of injury, prosecutors and children's lawyers should consult medical professionals and review the relevant scientific literature.

Lawyers cannot evaluate scientific theories properly, but they can determine whether a particular theory might be valid in the context of their case. When considering an alternative theory of how a child was injured, lawyers should consult with physicians about whether that theory is generally accepted in the medical community. See [Frye v. United States](#), 293 F. 1013, 1014 (D.C. Cir. 1923). Lawyers also should ask physicians whether they are aware of any scientific data in support of the theory and whether the theory has been published in peer-reviewed studies. See [Daubert v. Merrell Dow Pharm., Inc.](#), 509 U.S. 579, 593–94 (1993).

While AHT/SBS is a well-settled diagnosis in the scientific community, it is frequently challenged in court. Typically, a defense attorney will claim that the injured child had a disease or disorder that mimics AHT/SBS or that the injury was caused by a fall or other accident. As discussed above, children's hospitals generally have doctors who already will have eliminated disease and accident as causes of injury. Therefore, a prosecutor or lawyer considering the interests of an abused child should consult the treating physicians about the defense claim. In some cases, however, they might find an expert in a particular disease to explain why it should—or should not—be ruled out as a cause of injury.

### **Conclusion**

The injuries of AHT/SBS are strong evidence that a child has been severely abused, and there is broad scientific consensus supporting this conclusion. AHT/SBS investigations, however, are complicated and always should include a thorough medical examination by a diverse group of pediatric doctors. When police officers, social workers, and lawyers encounter these cases, they should carefully consider the medical diagnosis while conducting a thorough investigation of their own. If investigations are conducted carefully, public officials and attorneys can protect vulnerable children while minimizing the possibility of wrongful convictions.

**Keywords:** litigation, children's rights, shaken baby syndrome, abusive head trauma, child abuse

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## Litigating Shaken Baby Syndrome Allegations in the Child Welfare Context

By Melissa L. Staas – June 18, 2015

The past 10 years have brought to bear a new perspective to what child and family advocates had been taught about shaken baby syndrome (SBS), recently relabeled abusive head trauma (AHT). Throughout the 1980s and 1990s, highly publicized criminal trials and ubiquitous public health campaigns warned of the dangers of violently shaking an infant. While there is value in educating the public that shaking an infant can lead to serious injury, just because violent shaking can result in injury does not mean that the opposite is true: that when you find an injury, you can conclude that violent shaking is the cause. Nonetheless, in the wake of the heightened public awareness, a medicolegal paradigm developed that adopted this assumption of abusive causation whenever certain medical findings are present (i.e., subdural hematoma, retinal hemorrhages, and brain swelling, either separately or in some combination). Applying this framework, some physicians began diagnosing the presence of SBS/AHT—and, thereby, making a legal conclusion that abuse had occurred—even in the absence of any other injuries, any external signs of abuse or maltreatment, or any other direct evidence (e.g., a witness to the violence being alleged) or circumstantial evidence (e.g., history of violence) supporting the accusation of abuse.

The spring issue of *Children's Rights Litigation* included an article by Katherine Judson, an attorney and clinical instructor with the Wisconsin Innocence Project at the University of Wisconsin Law School, who serves as the national coordinator of legal work exonerating persons who have been wrongly accused of SBS/AHT in the criminal system. Judson's article, "[What Child Welfare Attorneys Need to Know about Shaken Baby Syndrome](#)," provides an introduction to the shortcomings of the medicolegal SBS/AHT paradigm and outlines why an immediate presumption of abuse based solely on the presence of a subdural hematoma, retinal hemorrhaging, and/or brain swelling must be closely scrutinized due to the existence of countless nonabuse explanations for those same findings, including accidental trauma and natural disease processes. This caution regarding an SBS/AHT determination has become well-pronounced in the criminal justice system, where attorneys practicing innocence work have devoted time, attention, and care to objectively evaluating the validity of criminal convictions based on an SBS/AHT accusation. See, e.g., Deborah Tuerkheimer, *Flawed Convictions: "Shaken Baby Syndrome" and the Inertia of Injustice* (2014). This innocence work has resulted in precedent-setting judicial decisions overturning criminal convictions and questioning the theories upon which state medical experts have rested their opinions of abusive causation. See, e.g., [Del Prete v. Thompson](#), 10 F. Supp. 3d 907, 957 n.10 (N.D. Ill. 2014) (noting that "a claim of shaken baby syndrome is more an article of faith than a proposition of science"); [New York v. Bailey](#), No. 2001-0490 (N.Y. Monroe Cnty. Ct. Dec. 16, 2014) ("[A] significant and legitimate debate in the medical community has developed in the past 13 years, over whether young children can be fatally injured by means of shaking[.]"); [Ex parte Henderson](#), 384 S.W.3d 833, 833–34 (Tex.



Crim. App. 2012) (“[T]here is no way to determine with a reasonable degree of medical certainty whether [the child’s] injuries resulted from an intentional act of abuse or an accidental fall.”); [State v. Edmunds](#), 746 N.W.2d 590, 598–99 (Wis. Ct. App. 2008) (declaring the “emergence of a legitimate and significant dispute within the medical community as to the cause” of injuries historically attributed to SBS/AHT). Even United States Supreme Court justices have viewed convictions based on a diagnosis of SBS/AHT with suspicion. See [Cavazos v. Smith](#), 132 S. Ct. 2, 14–27 (2011) (Ginsburg, J., dissenting) (“What is now known about shaken baby syndrome (SBS) casts grave doubt on the charge leveled against Smith[.]”).

Despite this shift in the criminal justice system, attorneys and judges in the field of child welfare law have not been at the center of the developing critique of the SBS/AHT diagnosis. Additionally, the types of cases that may enter the child welfare system and the consequences that can follow often differ in material ways from the cases that are criminally adjudicated. Given that the stakes in the child welfare system include the very real, irreversible, and sometimes permanent trauma that a misdiagnosis of SBS/AHT causes to children, legal professionals in the child welfare system should apply the same diligence and objectivity when confronted with an SBS/AHT case as has been modeled by innocence projects nationwide.

### **Diminished Strength of the Medical Evidence Supporting Claims of SBS/AHT**

For many families whose lives are torn apart and irreparably harmed due to a poorly supported claim of SBS/AHT, the criminal system is never involved. In many cases, law enforcement and prosecutors decline to file criminal charges because there is insufficient evidence. Nonetheless, due to the uniqueness of the child welfare system—which, as is discussed more fully below, is predicated on a lower burden of proof and does not necessarily require the state to prove who caused the claimed abuse—the family can still be subjected to a child protection case. A child protection case involves an investigation conducted by case workers who may be trained to simply adopt the conclusions of the child abuse pediatrician, who will make a determination as to registering a substantiated claim of abuse against the accused person in the child abuse registry. Commonly in cases where SBS/AHT is being alleged, the child welfare investigations will result in the removal of the accused person’s children from their care, with a dependency court action initiated following that removal. These state actions result in prolonged, excruciating, and expensive legal proceedings, during which time the accused persons must endure the unrelenting accusation that they have viciously harmed a child in their care, often their own child.

The following is one example of a case currently being handled at the [Family Defense Center](#):

“Leah,” a long-time kindergarten teacher, had gotten up in the middle of the night to tend to her seven-month-old infant, “Owen,” who was crying. As she started walking down the stairs, she slipped while holding Owen and he fell out of her arms, hitting his head on the baseboard. Leah and her partner, “Jacob,” immediately took Owen to the hospital, where he was found to have a subdural hematoma and retinal hemorrhages.

Child protection and criminal investigations ensued. The criminal case initially resulted in a charge of “endangering the life/health of a child” based not on a claim of abuse, but because Leah had dropped Owen. However, this criminal charge of neglect was promptly withdrawn by the prosecutor. Nonetheless, a child protection petition was filed in the state dependency court; the state sought to place Owen in foster care and asked the court to enter findings of abuse—findings that, if entered, will permanently ruin Leah’s career. However, the case supporting a claim of abuse has only weakened since the date the petition was filed. Owen’s treating neurosurgeon has confirmed that in addition to the fall, Owen had an underlying medical condition rendering him particularly susceptible to intracranial bleeding and retinal hemorrhages from minor or incidental trauma. But in the face of a child abuse pediatrician opinion that has not been modified to take into account the neurosurgeon’s opinion, the state has not considered withdrawing its child protection petition. As of May 2015, the family has remained in legal limbo for over eight months.

Because most jurisdictions require the state to prove abuse in child welfare proceedings only by a preponderance of the evidence standard, cases like Owen’s—where there is a plausible nonabuse explanation supported by qualified medical subspecialists—will enter the child protection system even though they would never pass muster for a criminal adjudication. Another key difference between criminal cases and child protection cases is the long-term prognosis for the infant. It is more likely that cases in the child welfare system involve nonlethal occurrences, whereas many of the criminal cases involve a child who has died. In the dozens of cases based on an SBS/AHT accusation the Family Defense Center has handled, for example, there has not been a single death involved and almost every single infant, with perhaps one or two exceptions of health complications stemming from the underlying medical conditions, has proceeded to fully recover and thrive.

The system responds to the lower standard of proof by including within its purview cases where the evidence of SBS/AHT is tenuous and, sometimes, questionable at the outset, particularly cases where there are multiple witnesses to an accidental fall or where multiple subspecialists have identified a preexisting medical condition. The lower burden of proof can also cause confusion for the doctors rendering the abuse opinion, leading them to think that “reasonable degree of medical certainty” means something much more relaxed than the level of certainty they would be expected to profess in any other case. Indeed, sometimes doctors and attorneys working with them confuse the degree of certainty they should have with the “more likely than not” understanding of the “preponderance of the evidence” standard. Just because a case *can* be brought into the system based on evidence that could never support a criminal conviction, however, does not mean that it *should*. The diminished burden of proof in child protection proceedings means that the rate of error is elevated and the damage caused by an erroneous finding of SBS/AHT is significant and lasting. In practice, the “preponderance” standard must be applied strictly and meaningfully in order to protect children and parents from destructive proceedings based on an under-supported claim of SBS/AHT, particularly when alternative nonabuse explanations have been provided.

### **Reliance on Child Abuse Pediatricians**

In 2010, the American Academy of Pediatrics certified a new subspecialty in child abuse pediatrics, which requires a fellowship with a teaching hospital's child protection unit and a separate board exam. While initially envisioned as providing increased public health support for child abuse assessment models, this new subspecialty has generated questions regarding the investigatory or prosecutorial role assumed by child abuse pediatricians in many jurisdictions; the qualifications of child abuse pediatricians to be rendering opinions in highly specialized fields of medicine such as forensic pathology, neurosurgery, radiology, retinal surgery, and orthopedics; and the nature of "child abuse" as a medical diagnosis given the legal conclusions embedded within such an opinion. See George J. Barry & Diane L. Redleaf, [\*Medical Ethics Concerns in Physical Child Abuse Investigations: A Critical Perspective\*](#) (2014).

Child protection investigators are explicitly trained by their agencies to defer to the opinions of the child abuse pediatricians rather than sort out competing opinions of various specialists. Complicating matters is the reluctance of other treating subspecialists to vocalize any disagreement they may have with a child abuse pediatrician's opinions, due either to an aversion to getting involved in controversial legal proceedings or to a presumption that the child abuse pediatrician is conducting a thorough differential diagnosis based on information not available to the subspecialist. Most concerning, however, is the readiness of judges in dependency courts to defer to whichever doctor has been denominated as the "child abuse expert" even when that doctor's expertise as to the medical conditions at issue is objectively less than the expertise of testifying subspecialists. Take, for example, the case of [\*In re Yohan K.\*](#), 993 N.E.2d 877 (Ill. App. Ct. 2013):

Following a precipitous birth, Teresa G. and K.S. observed their newborn son, Yohan, to exhibit strange behaviors such as yelping spontaneously and staring into space. When he was approximately four weeks old, the concerned parents brought Yohan to see the pediatrician yet again and the pediatrician observed seizure activity. Yohan was brought to the hospital where he was found to have subdural and subarachnoid hematomas as well as bilateral retinal hemorrhages. It was also suspected, based on inconclusive skeletal imaging, that he had a fracture to his left knee despite exhibiting no clinical signs of having an injury to his knee. At trial, a pediatric radiologist/neuroradiologist testified that Yohan had both "benign enlargement of the subarachnoid spaces," which would account for the intracranial and retinal findings, as well as congenital rickets, which had been misidentified as a fracture. A pediatric neurosurgeon concurred regarding the intracranial and retinal findings, while a pediatric orthopedist concurred regarding the misdiagnosis of a fracture. Despite this strong and undeniable evidence in favor of medical nonabuse explanations, the trial judge determined that because the state's child abuse pediatrician had explained it was "unlikely" that Yohan would have two rare medical conditions, the state had met its burden of proving that Yohan had been abused.

The Family Defense Center represented Yohan's parents on the appeal. In a precedent-setting opinion, the Illinois Appellate Court found that the parents had "been thrust into a nightmare by

well-intentioned, but misguided doctors and child protection specialists” and that the trial court had erroneously rejected the medical explanations for the child’s conditions. *Yohan K.*, 993 N.E.2d at 879. Specifically, the appellate court found that the state’s experts had “speculated and generalized about the possible mechanisms causing the injuries in areas outside of their expertise.” *Yohan K.*, 993 N.E.2d at 900. Without outstanding trial counsel (private attorney Ellen Domphe, who had extensive experience in medically complex litigation), detailed briefing by our office, and, most importantly, a thoughtful appellate court panel willing to rigorously review the evidence, however, the family would have forever lived under a stigmatizing cloud of suspicion. As it was, the children were separated from their parents for 15 months, and the family lived under the cloud of the abuse finding for two years. The parents in the *Yohan K.* case were highly educated, had an extensive support system, and were able to access experienced counsel and doctors willing to testify on their behalves. In this case, criminal charges had never even been considered. The trial judge in the *Yohan K.* case, however, had mistakenly assigned to the child protection pediatrician a superior level of expertise and adopted her mistaken view that the rarity of multiple conditions made an abuse explanation more plausible. Indeed, the appellate court criticized the state’s doctors for not engaging in a true differential diagnosis when evaluating the potential causes for Yohan’s medical findings.

Child protection investigators may also be more inclined than law enforcement or prosecutors to defer to nonmedical conclusions of a child abuse pediatrician, such as determinations of a parent’s credibility, speculations as to a parent’s mental health, or the physician’s own personal anecdotal experience with infants.

Three-month-old “Alison” was being cared for by multiple caretakers, including two nannies. While in the care of one of her nannies, she began experiencing seizure-like activity. The family brought her to the hospital where she was found to have bilateral subdural effusions, acute left-side subdural and subarachnoid hematomas, and retinal hemorrhaging. Despite the parents describing three incidents of accidental trauma and the presentation of a preexisting medical condition, the child abuse pediatrician held fast to her conclusion that abuse had occurred. After the parents appealed the administrative “abuse” finding that had been registered against them, however, they learned that the child abuse pediatrician based her abuse diagnosis on the father’s having reportedly failed two questions on a polygraph test and that it was this credibility judgment—not a medical opinion—that formed the basis for the doctor’s abuse conclusion.

These cases demonstrate how crucial it is for child welfare attorneys to scrutinize the reasoning underlying the opinions of the involved doctors, including the child abuse pediatrician, and to discount those opinions if they exceed the scope of the doctor’s expertise or if they are based on anecdotal and/or nonscientific suppositions.

### **Nonoffending Parents Are Unfairly Swept into the Court's Jurisdiction**

“Stephanie,” a high school teacher, was out running errands with her four-year-old daughter while her husband, “Patrick,” was home with their three-month-old son, “David.” While under Patrick’s care, David suddenly began breathing erratically and showing signs of a seizure. Patrick administered efforts to resuscitate David, including “shaking” him several times trying to get his attention, and called 911. David was brought to the hospital and found to have subdural hematomas and retinal hemorrhages. Although some of the treating doctors initially believed David to have “new” as well as “old” hematomas, it was quickly established that the fluid collections diagnostic for “benign enlargement of the subarachnoid spaces” had been misidentified as “old blood.” No criminal charges were ever filed, but David and his sister were taken into state custody and child protection proceedings ensued.

The state’s case quickly settled on Patrick as the presumed abuser, based on a faulty presumption that David must have experienced physical trauma immediately prior to exhibiting symptoms. Even though the state never suspected Stephanie of having caused the abuse, under the statutory framework governing dependency proceedings in Illinois, she was still subject to the jurisdiction of the court due to a petition having been filed as to her children. Moreover, the state argued that Stephanie’s insistence that there was a medical explanation for David’s findings meant that she would be unable to protect her children from harm. In order to persuade the state and the court that she should be permitted to have her children returned to her, Stephanie was compelled to file for divorce. Ultimately, due to the weaknesses in the medical claims of SBS/AHT and the existence of a preexisting medical condition, the state agreed to withdraw its petition after a period of supervision, but the destruction of the family unit had already occurred.

Unlike a criminal case, where the prosecution must prove beyond a reasonable doubt that the accused person committed the alleged abuse, child protection cases in most jurisdictions proceed without requiring determinations as to “who” caused the abuse. Rather, the initial focus of adjudication in dependency proceedings is the status of the child as abused and not the fault of a specific parent. *See, e.g., 705 Ill. Comp. Stat. 405/2-2, 2-3; In re Arthur H.*, 819 N.E.2d 734 (Ill. 2004). As a result of these arguably unconstitutional statutory frameworks—which run afoul of Supreme Court holdings prohibiting the state from interfering with a parent’s fundamental rights without findings as to that parent’s unfitness, *see Troxel v. Granville*, 530 U.S. 57 (2000); *Stanley v. Illinois*, 405 U.S. 645 (1972)—the nonoffending parent’s relationship with his or her children is not adequately protected. This is especially true in cases of SBS/AHT, where the involved entities, sometimes even the judge, are often unduly prejudiced by the severity of the accusations being made.

### **Permanent State Action Without “Post-Conviction”-Type Recourse**

Any child protection case that enters the dependency courts is vulnerable to an eventual permanent termination of parental rights. This has often been analogized as the family law equivalent to the death penalty. Although parents can pursue direct appeals from orders

terminating their parental rights, the reviewing courts give great deference to the trial courts, often in the interest of permanency for the children. Moreover, once the direct appeal options have been exhausted, there generally is no possibility of a future remedy based on new evidence (such as updates in the scientific and medical understanding of SBS/AHT) or ineffective assistance of counsel. This is unlike criminal proceedings, where post-conviction proceedings are common. The results can be tragic, enshrining medical and legal mistakes (of the sort that have been corrected in post-conviction cases) in life-altering permanent severance of the legal relationships between parent and child.

When Aidden was two months old, his mother, Emily, and his father brought him to the hospital with respiratory distress. Scans revealed the presence of both “old” and “new” subdural hematomas. There were no retinal hemorrhages, but there was some alleged bruising on Aidden’s right cheek, sternum, and diaper area. Both parents were charged with Class X felony aggravated battery of a child. Simultaneously, the state took protective custody of Aidden and initiated a case in dependency court. While the criminal proceedings were still pending, the child protection court entered a finding that Aidden had been abused.

Approximately one year later, a forensic pathologist issued a report showing that Aidden had a rapidly increasing head circumference following birth consistent with “benign enlargement of the subarachnoid spaces,” making him more susceptible to intracranial bleeding. Additionally, the “old” blood could be attributed to birth trauma. The expert also stated that some of the bruising was more consistent with diaper rash, not contusions. Following this report, the prosecutor dismissed all criminal charges against Emily and reduced the father’s charge to a Class 4 felony reckless conduct based on the father having reported that he fell and tripped on top of Aidden while running up a flight of stairs. One year after the criminal charges were dropped, the dependency court terminated Emily’s parental rights on the grounds that she had failed to make reasonable progress in services.

Because the child protection court had already made the determination that Aidden was abused, and because the parents did not appeal that finding immediately after it was entered, they were stuck with that determination for the remainder of the case despite the subsequent issuance of an expert report that convinced the prosecutor to virtually dismiss all criminal charges. In the end, that determination came back to haunt them when the state sought to terminate their parental rights. Notably, the suspicion of abuse was always focused on the father, due to Aidden being with him at the time he became symptomatic and an early claim that he admitted to shaking the baby on one occasion.

Emily appealed the termination orders and was unsuccessful in the appellate court. [\*In re Aidden S.\*](#), No. 2-14-0085 (Ill. App. Ct. May 16, 2014). Emily came to the Family Defense Center only after the appellate court had affirmed the trial court’s ruling of termination. Due to the blatant injustice of her case, our office partnered with the law firm of Stinson Leonard Street to request

that the Illinois Supreme Court accept the case for review. The record revealed that during the entire time her son was in foster care, Emily never missed a visit with him and attended almost all of his doctors' appointments, efforts that required her to travel hundreds of miles each time. A licensed clinical social worker retained by the state conducted a parenting capacity assessment and, finding Emily to be an exceptional mother, recommended that Aidden be returned to her. Nonetheless, Emily was found to be unfit because she didn't follow up on referrals for counseling and she wouldn't discuss what she could have done to protect her son from his injuries (despite the evidence that there were medical explanations for his findings).

Unfortunately, the Illinois Supreme Court denied our request to appeal the termination, and Aidden and his mother have been left without any recourse to correct the injustice perpetrated on them. This predicament was caused in no short measure by the failure of the trial attorneys to aggressively question the underlying SBS/AHT claim in the child protection proceedings, particularly when the report of the forensic pathologist was issued. Our review of the child protection record revealed not a single mention of the expert report that had vanquished the criminal case. This single omission is, by itself, a grave miscarriage of justice.

### **Conclusion**

Child welfare lawyers and judges need to be aware that SBS/AHT diagnoses may be flawed. Failure to critically review such diagnoses in a timely and rigorous manner in dependency cases, termination of parental rights cases, and registry appeals can result in traumatic and unfair determinations that permanently affect children and families' lives. Advocates for families need to learn from advocates in criminal cases to question the evidence against parents and challenge unscientific conclusions. Fortunately, as the case law and science continue to develop, and as child welfare attorneys become better educated about SBS/AHT, innocent families can experience increased justice and exoneration in the child welfare system as well as in the criminal courts.

**Keywords:** litigation, children's rights, shaken baby syndrome, abusive head trauma, child abuse, child protection proceedings, preponderance of the evidence

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## A Call for Pro Bono Assistance for Unaccompanied Immigrant Children

By Meredith Linsky – June 18, 2015

*Editor's Note:* Excerpts from this article are taken from Cheryl Zalenski, "[The Need for Pro Bono Assistance to Unaccompanied Immigrant Children](#)," *Cornerstone* (Nat'l Legal Aid & Defender Ass'n), Jan.–Apr. 2015, at 14.

### The Critical Need

One year ago, during the summer months of 2014, the media focused attention on the plight of unaccompanied children from Central America who came streaming across the U.S. border, fleeing from gang and cartel violence, abuse, and poverty. These children risked their lives traveling north, hoping to find safety, protection, and opportunity in the United States. They also came seeking to reunify with family members already living and working in the United States; close to 50 percent of these children are reported to have at least one parent in the United States from whom they had been separated for two, five, or even 10 years. These children were either apprehended or turned themselves over to Border Patrol agents, mostly in remote South Texas. The number of children entering the United States increased tenfold from an average of 7,000 in 2011 to almost 70,000 in fiscal year (FY) 2014.

What was once characterized by President Obama as an "urgent humanitarian situation" at our southwest border has turned into a present-day crisis in our nation's overloaded immigration court system. Upon apprehension, the children are immediately placed in adversarial removal proceedings and required to appear in immigration court. Unfortunately, these children are not provided appointed legal representation in the ensuing immigration proceedings. Regardless of age and fluency in English, children frequently appear in immigration court without legal counsel. Currently, only about 32 percent of the children in removal proceedings are represented. The presence of legal counsel is vital to the outcome in these cases and the single most important factor in determining the outcome. Data indicates that children represented by an attorney appear much more frequently in court (92.5 percent) than those without an attorney (27.5 percent). Further, a recent study reviewing data from FY 2012 through FY 2014 indicates that 73 percent of children who are represented in immigration court are ultimately successful in remaining in the United States, while only 15 percent of unrepresented children are similarly successful. Pro bono legal assistance is critical to ensuring that these children are screened adequately for legal relief and receive essential due process protections.

### The American Bar Association's Response

ABA leaders were able to witness firsthand the pressing issues confronting these children during a July 2014 visit to Lackland Air Force Base and other youth shelters on the southwest border, including the critical need for legal representation in immigration court and related proceedings. In response to this need, ABA President William Hubbard, with the approval of the Board of Governors, established the Working Group on Unaccompanied Minor Immigrants in late August 2014. In support of its charge to recruit attorneys to represent unaccompanied children, the

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working group has developed a [website](#) to collect ABA training materials and policy on the issue, as well as links to external sources. Additionally, attorneys can volunteer to provide pro bono legal assistance through a link on the webpage. The working group also supported Pro Bono Net's development of the [Immigration Advocates Network website](#) dedicated to this issue. This site offers pro bono attorneys resources, including a calendar of trainings, a library of documents, podcasts, a guide to pro bono opportunities, and more. The site also offers similar resources for the provider organizations and for the children and their families.

### **Making the Case for Pro Bono**

Private attorneys may be reluctant to volunteer to assist children in immigration matters, as it is an area of law in which relatively few have experience, but the need among these children is too great to ignore. As minors, unfamiliar with the American and immigration court systems and law, they are at a great disadvantage. Many have no or limited fluency in English. While most of the children are teenagers, some are as young as four or five years old, or even younger. The best assurance of due process for these children is the presence of an attorney, who has a far greater knowledge of the proceedings—even if it is not his or her area of expertise.

Attorneys interested in providing pro bono services to children can build their knowledge and expertise through a variety of resources. In addition to the websites mentioned above, a number of organizations exist across the country to provide training and mentoring to attorneys new to immigration matters like [Kids in Need of Defense](#) (KIND), and the [U.S. Committee for Refugees and Immigrants](#) (USCRI).

Providing pro bono legal services to immigrant children can also be a deeply satisfying experience, giving attorneys the opportunity to positively affect a young person's life and obtain a measure of security and safety the child may have never previously experienced.

In addition to the intangible benefits, volunteering to provide pro bono legal assistance offers professional development. Attorneys gain experience in interviewing clients and fact finding. They will also gain litigation experience appearing before a judge in immigration court; or possibly in family law court if they represent a child in a special immigrant juvenile status (SIJS) matter. This valuable experience is applicable and transferable to the attorney's daily practice and business and will forever remain a personally memorable experience.

### **Conclusion**

The influx of unaccompanied children from Central America in 2014 was unprecedented in comparison to previous years, and although the numbers are currently down by about 50 percent from last year, they are still much higher than before 2012. This is due to the fact that the conditions in Central America have not changed and continue to remain a threat to the security of families and children residing there. Nelson Mandela once said, “[t]here can be no keener revelation of a society's soul than the way in which it treats its children.” Today, it is up to the legal community to respond and provide these children with the care and representation they deserve.

**Keywords:** litigation, children's rights, unaccompanied child immigrants, immigration court, removal proceedings, due process, pro bono opportunities

Meredith Linsky is the director of the [ABA Commission on Immigration](#) in Washington, D.C. Previously, she spent 15 years on the Texas-Mexico border as the director of ProBAR, the South Texas Pro Bono Asylum Representation Project, a pro bono project sponsored by the ABA.

## Unaccompanied Child Immigrants: Representation Needs and Efforts

By Monique Sherman – June 18, 2015

If you have turned on the news recently, chances are you have heard about an unprecedented “surge” in the number of unaccompanied minors and families from Central America entering the United States at the southern border over the past year. Almost 70,000 unaccompanied minors entered the United States primarily from El Salvador, Guatemala, and Honduras in 2014. If they are apprehended at the time of entry or thereafter, they are generally placed in removal (deportation) proceedings in immigration court. Many of these children are eligible for special immigrant juvenile status (SIJS) or asylum. But, they need attorneys to assist them in presenting these claims. Without an attorney, unaccompanied children are ordered removed approximately 90 percent of the time. With an attorney, over 70 percent of such children are allowed to stay in the United States. From a process point of view, an influx of so many unrepresented respondents in immigration courts around the country has overwhelmed the courts. In an effort to ensure the process runs smoothly, Vice President Joe Biden urged pro bono legal assistance for children in August 2014.

Around the country, the legal community has developed various approaches to meeting the intense need for representation among young people in removal proceedings. Here, readers will find a short description of the legal help that is needed, two models for providing that assistance, and resources available for volunteer attorneys who represent unaccompanied minors and those who would like to become involved.

### The Need for Legal Representation

Most young people who arrive in the United States and who are placed in removal proceedings will apply for one of two forms of relief: SIJS or asylum. (For a detailed summary of each claim, see Annie Chen, “[An Urgent Need: Unaccompanied Children and Access to Counsel in Immigration Proceedings](#),” 16 *Children's Rts. Litig.*, no. 4, Summer 2014, at 2.). They need attorneys to represent them in immigration court so that they can obtain continuances while they work on obtaining legal counsel and to help them pursue the appropriate form of relief. The following descriptions of those processes are merely an overview of what one of these young people needs to do in order to stay in the United States. Each is the subject of in-depth trainings offered by various legal services providers. It is no wonder that children who came here without even their parents need representation in order to have a chance of success in this process.

**Removal proceedings.** Young people who have arrived in the United States since June 2014 often face court hearings every few weeks (in stark contrast to the typical immigration court continuance, which can be months, if not years long). The length of continuances between court dates varies by jurisdiction, but in most jurisdictions, individuals who have arrived since June 2014 have been placed on “surge” dockets with frequent court appearances. At these court hearings, attorneys are needed to assist respondents to request continuances in order to obtain ongoing counsel. After ongoing

counsel is obtained, and while such counsel pursues the appropriate claims for relief, the limited pro bono counsel appears in court at the continued hearings and/or requests that the court administratively close or terminate the proceedings while claims for relief are adjudicated.

**Special immigrant juvenile status (SIJS).** This is a special form of relief for young people who were abused, abandoned, or neglected by one or both parents with whom reunification is therefore not a viable option. In order to apply for SIJS, the child must obtain a state court order placing him or her in the custody of an individual or agency. The child also must obtain special findings from the state court verifying that the child has been abused, abandoned, or neglected by a parent, that reunification with that parent is not viable, and that returning to the child's home country is not in his or her best interest. Once the child has obtained these findings, he or she can apply to the U.S. Citizenship and Immigration Services (USCIS) for SIJS. If the immigration court terminates removal proceedings, the child can also apply to adjust immigration status to that of a lawful permanent resident. If proceedings are not terminated, the child can still apply to the court to adjust his or her status.

**Asylum.** Many of the young people who are part of the "surge" are additionally, or alternatively, eligible for asylum. Individuals who have a well-founded fear of persecution in their home countries on the basis of race, religion, national origin, political opinion, or membership in a particular social group are eligible for asylum. Most of the young people in this wave have fled intense violence by the gangs, such as the MS-13, that are prevalent in Central America. Those who were targeted due to a specific characteristic or due to their own behavior can claim persecution on the basis of membership in a particular social group.

Although adults must pursue these claims in court in an evidentiary hearing, children who arrived unaccompanied may submit the asylum application for adjudication to USCIS. Instead of an evidentiary hearing, they have an interview with an asylum officer in a nonadversarial setting.

## Two Responses

**New York City.** In New York, a coalition of legal services organizations has staffed the surge dockets at immigration court on a daily basis. In addition, the [Legal Aid Society](#), [The Door](#), and [Make the Road](#) are operating a pro bono model that brings in volunteers to screen clients before they get to the courtroom. These screenings are used to refer the potential clients to the appropriate legal services organization or pro bono counsel. These pro bono opportunities are bite-sized, given that they only entail the initial screening.

Other organizations, such as the [New York Legal Assistance Group](#) and [New York Immigration Coalition](#), are hosting regular legal clinics where legal services attorneys,

together with pro bono volunteers, perform legal intake and help clients understand their potential legal avenues for relief from deportation. Again, this is a one-time pro bono opportunity so that even lawyers with limited time can get involved and assist with the crisis.

**San Francisco.** In San Francisco's Immigration Court, unrepresented respondents have long been assisted by the San Francisco Bar Association's (BASF's) Attorney of the Day Program. The Attorney of the Day Program is an application-only program and is intended to be staffed by attorneys with significant immigration experience. When the "surge" dockets began in San Francisco on very short notice, the BASF stepped up recruitment efforts among private immigration attorneys to staff these dockets. Additionally, attorneys from legal services organizations, such as [Centro Legal de la Raza](#) and [Community Legal Services in East Palo Alto](#) (CLSEPA), among others, began staffing specific dockets to help the community. These attorneys perform legal intake with the respondents, represent them in their master calendar hearings that day, and help ensure they have the appropriate referrals to obtain ongoing representation.

Additionally, while the legal services providers continue to refer clients to pro bono counsel for assistance with their SIJS and asylum applications, these organizations have also formed a coalition funded by the City of San Francisco. Through this coalition, the organizations have been able to hire additional attorneys to represent this population of unaccompanied minors in their removal proceedings and applications for relief, and to do the work necessary to refer such clients to pro bono counsel.

Many of the legal services organizations that handle immigration cases and refer them to pro bono counsel additionally host regular intake workshops or legal clinics at which prospective clients may come to be screened for legal relief and to be referred to counsel.

In June 2015, San Francisco's Immigration Court implemented the preexisting plan for its new juvenile docket. Young people who entered the country previous to June 2014 have been placed on this docket. CLSEPA is coordinating a pro bono volunteer effort to meet with young people prior to their court appearance, perform legal intake, and represent them on a limited basis at the court hearing.

#### **A Note about the Need for Representation of Adults with Families**

In addition to the large number of unaccompanied minors who need representation, there are thousands of children who made this same journey north with their parents, for many of the same reasons. Some of these families are detained, sometimes for months, at one of the family detention centers. Congressional leaders have expressed concern around conditions of detention for mothers and children. *See* Elise Foley, "[Backlash Against Mass Family Immigrant Detention Grows as Senate Democrats Pile On](#)," *Huff Post Politics* (June 2, 2015). All of these families, detained or not, must pursue their asylum claims in court, where they have also been placed on

dockets with accelerated schedules. This population has even less access to legal services than unaccompanied immigrant children.

### **Conclusion**

Throughout the country, legal services organizations and pro bono attorneys have been working around the clock to ensure that as many of these young people as possible have access to representation. Private funders and federal, state, and local governments in a variety of locations have stepped up to fund legal services organizations in recognition that the expertise at those organizations is what enables their work to be leveraged by pro bono volunteers.

Unfortunately, many young people are still in need of representation to avoid being sent back to dangerous situations in their home countries. Attorneys interested in volunteering to represent these clients should explore the resources below to find out which organizations in their local area have cases to refer. Attorneys can indicate their interest in volunteering on the [Immigrant Child Advocacy Network](#) website, and can search for organizations on the [Unaccompanied Children Resource Center](#).

In addition, a Yammer website has been launched specifically to link lawyers around the country representing unaccompanied immigrant children—whether full-time or on a pro bono basis, so that they can ask questions and share information. To learn more about the website, read the [article in the ABA News archive](#).

**Keywords:** litigation, children's rights, unaccompanied child immigrants, immigration court, removal proceedings, deportation, special immigrant juvenile status, asylum, legal services organizations, pro bono opportunities

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**NEWS & DEVELOPMENTS**

June 12, 2015

## **Response to "What Child Welfare Attorneys Need to Know about Shaken Baby Syndrome"**

Sandeep K. Narang, MD, JD, and Christopher S. Greeley, MD, MS, have written a response to the article ["What Child Welfare Attorneys Need to Know about Shaken Baby Syndrome"](#) which ran in the spring edition of Children's Rights. ["What Child Welfare Attorneys Need to Question About the Innocence Project's Information on Shaken Baby Syndrome/Abusive Head Trauma"](#) (login required) ran in the April/May 2015 Edition of The Guardian, a publication of the National Association of Counsel for Children.

—*Cathy Krebs, Committee Director, Children's Rights Litigation Committee*

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June 8, 2015

## **Law to Limit Use of Seclusion and Restraints on Children in Connecticut**

On Wednesday, May 27, 2015, Connecticut lawmakers passed a [bill](#) limiting the use of seclusion rooms and restraints on children in the state's schools. Connecticut's current law regarding seclusion and restraints allowed children to be locked alone in rooms for indefinite periods of time and restraints to be used with little oversight. The Office of the Child Advocate (OCA) has found that children, some as young as pre-school aged, were being placed in seclusion, including those on the autism spectrum. The OCA additionally found that the children being restrained or secluded were largely African American or Hispanic, and found that over the last three years, more than 1,300 incidents included injury to the child during the restraint or seclusion. The new law would increase monitoring and reporting of the practice of using restraints or seclusion, and requires that parents must be notified within 24 hours of the child being placed in seclusion. The law sets forth strict limits on the use of restraint and requires all seclusion rooms to have windows. Connecticut's multi-tiered law begins to take effect on July 1, 2015, with some provisions not being implemented until 2019.

—[Jessalyn Schwartz](#), Boston, MA; Member of the ABA Children and the Law Advisory Task Force

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May 21, 2015

## ICAN Yammer Group

The American Bar Association Working Group on Unaccompanied Immigrant Minors and the [Immigrant Child Advocacy Network](#) recently launched the ICAN Yammer group, an online community that supports pro bono attorneys new to immigration law and representation of children. The resource, developed in collaboration with Section of Litigation sponsor [Navigant](#) leverages the expertise of mentors and experts nationwide. The ICAN Yammer group also serves as a platform to aggregate and share materials related to representation of children in both immigration court and state court proceedings. Yammer is the Microsoft enterprise social network for business. Access is provided by [invitation only](#). This extraordinary and unique effort arose due to a need identified by Navigant through their involvement with the Section of Litigation's Children's Rights Litigation Committee. The Section is grateful to Navigant and Microsoft for their commitment to assisting on this critical issue.

—Cathy Krebs, Committee Director, Children's Rights Litigation Committee



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