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2010 Conference
A Success

In October, the NACC hosted its 33rd National Child Welfare, Juvenile, and Family Law Conference in Austin, TX. The conference included 107 faculty members, and drew 720 attendees — a NACC record! We are thrilled with the expertise and knowledge of the presenters, with the high quality content of the sessions, and with the active participation of the attendees.

NACC conferences would not be possible without member participation and dedication to the fields of child welfare, juvenile, and family law. The success of the conference is due in large part to your enormous contribution as members. Thank you!

The lead article contained in this edition of The Guardian was authored by 2010 NACC conference faculty member Sandeep Narang, MD / JD. His article, titled A Review of the Medical and Legal Literature on Abusive Head Trauma: Trial Advocacy Implications, is published in the 2010 NACC Law Manual, which is produced in conjunction with the annual conference. To order this year’s Manual, please contact the NACC.

Thank you again for your support of the NACC. Please save the date for the 34th NACC conference in San Diego, CA, August 29 – September 1, 2011. We hope to see you in San Diego!

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A Review of the Medical and Legal Literature on Abusive Head Trauma: Trial Advocacy Implications

by Sandeep Narang, MD/JD

Introduction

The modern scientific literature concerning the diagnosis of physical child abuse has developed for nearly a half century, benchmarked by The Battered Child Syndrome.2 A few articles in the last two decades have challenged the science for diagnosing one type of physical child abuse,3 i.e. abusive head trauma or AHT. In turn, these relatively limited challenges by very few physicians have been used to support law review commentary arguing that there is insufficient science to support convictions for abusive head trauma to children in general.4 It appears that by attacking specific ways of characterizing AHT, e.g. attacking use of one grouping of symptoms termed “Shaken Baby Syndrome,” some critics are creating an unjustified halo of doubt as to any diagnosis that a particular closed head injury is abusive. Only by publishing a much more comprehensive “rest of the story” can either misinformation or disinformation be answered. This review first very briefly summarizes current case law related to expert testimony on abusive head trauma (hereinafter AHT), and then follows with a more extensive analysis of leading and current medical articles on AHT with a particular focus on the best recent research. Finally, a few illustrations are given of the kinds of questions that can help a medical witness respond clearly that there is a solid science for diagnosing AHT and giving testimony regarding AHT in a specific case. Some of the information provided here is based on a law review article submitted by the first author, Dr. Narang, but not yet published.

The Current Law of Evidence

As recently as 2005, John E. B. Myers, a leading expert on child witness evidence,5 reviewed “shaken baby syndrome” as a specific form of child abuse, including ongoing medical-legal exchanges, and concluded that: “Shaken Baby Syndrome is an accepted medical diagnosis. The Syndrome is not novel, and is not subject to Frye or Daubert.”6 Nevertheless, if the appearance of sufficient controversy can be created it is likely to eventually increase the odds that dubious challenges in the courtroom will also increase. “Stirring the pot” by law review articles questioning the science of diagnosing AHT,7 requires patience of those who wish the law to accurately reflect the “total picture.” This means the patience to reexamine the law of evidence regarding medical testimony before gathering and weighing the extensive medical literature supporting AHT and comparing this literature to the paucity of new and independent research offered by critics of the diagnosis.

In 1993, the U.S. Supreme Court’s ruling in Daubert v. Merrell Dow Pharmaceuticals, Inc.8 changed the former standard for admitting novel scientific evidence. The Daubert Court held that the text of Rule 702, its drafting history, and prior case law (citing Beech Aircraft Corp v. Rainey9) mandated a “liberal” and “relaxed” approach to the admission of expert opinion testimony.10 The inquiry into admission of expert testimony/evidence was within the province of the trial judge. While the trial judge’s inquiry was to be a “flexible one,” the Daubert Court required trial judges to

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1 Sandeep Narang is Assistant Professor of Pediatrics, Child Abuse Division, University of Texas Health Science Center San Antonio, and an immediate past Fellow of Child Abuse Pediatrics at the University of Colorado School of Medicine.
3 These articles began with attacks on a specific characterization of AHT, e.g. abusive head trauma or AHT. In turn, these relatively limited challenges by very few physicians have been used to support law review commentary arguing that there is insufficient science to support convictions for abusive head trauma to children in general. It appears that by attacking specific ways of characterizing AHT, e.g. attacking use of one grouping of symptoms termed “Shaken Baby Syndrome,” some critics are creating an unjustified halo of doubt as to any diagnosis that a particular closed head injury is abusive. Only by publishing a much more comprehensive “rest of the story” can either misinformation or disinformation be answered. This review first very briefly summarizes current case law related to expert testimony on abusive head trauma (hereinafter AHT), and then follows with a more extensive analysis of leading and current medical articles on AHT with a particular focus on the best recent research. Finally, a few illustrations are given of the kinds of questions that can help a medical witness respond clearly that there is a solid science for diagnosing AHT and giving testimony regarding AHT in a specific case. Some of the information provided here is based on a law review article submitted by the first author, Dr. Narang, but not yet published.
4 The modern scientific literature concerning the diagnosis of physical child abuse has developed for nearly a half century, benchmarked by The Battered Child Syndrome. A few articles in the last two decades have challenged the science for diagnosing one type of physical child abuse, i.e. abusive head trauma or AHT. In turn, these relatively limited challenges by very few physicians have been used to support law review commentary arguing that there is insufficient science to support convictions for abusive head trauma to children in general. It appears that by attacking specific ways of characterizing AHT, e.g. attacking use of one grouping of symptoms termed “Shaken Baby Syndrome,” some critics are creating an unjustified halo of doubt as to any diagnosis that a particular closed head injury is abusive. Only by publishing a much more comprehensive “rest of the story” can either misinformation or disinformation be answered. This review first very briefly summarizes current case law related to expert testimony on abusive head trauma (hereinafter AHT), and then follows with a more extensive analysis of leading and current medical articles on AHT with a particular focus on the best recent research. Finally, a few illustrations are given of the kinds of questions that can help a medical witness respond clearly that there is a solid science for diagnosing AHT and giving testimony regarding AHT in a specific case. Some of the information provided here is based on a law review article submitted by the first author, Dr. Narang, but not yet published.
5 See, for example, Idaho v. Wright, 487 U.S. 805 (1988) in which Myers’ treatise is cited by the U. S. Supreme Court with approval.
6 MYERS ON EVIDENCE IN CHILD, DOMESTIC AND ELDER ABUSE CASES, Volume I, Frederick, MD: Aspen Publishers (2005), Section 4.15 in its entirety.
7 FN 2. Supra.
9 Frye v. United States, 293 F. 1013 (D.C. Cir. 1923). Expert testimony on novel scientific evidence was admissible only if the opinion offered was based on a “well-recognized scientific principle or discovery” that was “sufficiently established to have gained general acceptance in the particular field in which it belongs.”
10 488 U.S. at 169.
11 Daubert, 509 U.S. at 588.
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With regards to reliability, the Daubert Court stated that “the subject of an expert’s testimony must be ‘scientific…knowledge’.” The Court noted there were definitional differences between Science and Law on “reliability.” But the Court went on to state that “evidentiary reliability will be based upon scientific validity.” (emphasis in original). The Court enunciated four factors a trial judge could consider in the preliminary assessment of whether proposed testimony was scientifically valid:

1) whether a theory or technique could be (and had been) tested — also known as ‘falsifiability’ or ‘testability’;
2) whether the theory or technique had been subject to peer review and publication;
3) whether there was a known or potential rate of error; and,
4) whether there was general acceptance in the relevant scientific community.

The Court remarked that these factors were not a “definitive checklist or test,” but merely factors for “consideration” in a trial judge’s overall assessment. The Court concluded by stating:

The inquiry envisioned by Rule 702 is, we emphasize, a flexible one...The focus, of course, must be solely on principles and methodology, not on the conclusions that they generate (emphasis added).

With regards to relevance, the Court explained that expert testimony cannot “assist the trier in resolving a factual dispute,” as required by Rule 702, unless the expert’s theory is “tied sufficiently to the facts of the case.” The Court remarked, “Rule 702’s ‘helpfulness’ standard requires a valid scientific connection to the pertinent inquiry as a precondition to admissibility” (emphasis added).

In General Electric Co. v. Joiner, the Court expanded upon the Daubert standard. In particular, the Court analyzed whether existing scientific evidence can be generalized to address specific causal relationships. The plaintiff asserted that exposure to polychlorinated biphenyls had promoted the development of his small-cell lung cancer. The plaintiff argued that the evidence can be generalized to address specific causal relationships. The plaintiff asserted that exposure to polychlorinated biphenyls had promoted the development of his small-cell lung cancer. The plaintiff argued that the evidence can be generalized to address specific causal relationships.

Trained experts commonly extrapolate from existing data. But nothing in either Daubert or the Federal Rules of Evidence requires a district court to admit opinion evidence which is connected to existing data only by the ipse dixit of the expert. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered (emphasis added).

In Kumho Tire Co. v. Carmichael, the Court examined the issue of the extent of a trial court’s “gate-keeping” obligation. Did it extend only to expert testimony based upon “scientific” knowledge or did it also apply to expert testimony based upon “technical” and/or “other specialized knowledge?” In unanimously holding that a trial court’s “gate-keeping” obligation extended to ALL expert testimony, the Court remarked that Federal Rule of Evidence 702 “makes no relevant distinction between ‘scientific’ knowledge and ‘technical’ or ‘other specialized knowledge.” Assurance of reliability of expert testimony, whether “scientific” or based upon “technical or other specialized knowledge,” was still required.

In grappling with this issue, the Court remarked there will be witnesses “whose expertise is based purely on experience.” And, the Court anticipated there would be times when such proffered expert testimony would have to be excluded because the field which the expert belongs to lacks reliability. But other than citing astrology and necromancy as such exclusible disciplines, the Court gave no specific guid-

12 Id. at 589.
13 Id. at 589-590.
14 Id. at 590-591.
15 Id. at 593-594.
16 Id. at 593.
17 Id. at 594-595.
18 Id. at 591.
19 Id. at 591-592.
23 See Cecil, supra note 38 at 76.
26 Id. at 1174.
27 Id. at 1176.
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As the age of science has flourished, Science and Medicine have increasingly permeated the Law and played crucial roles in the courtroom.28 As our scientific world has grown increasingly complex, courts have become increasingly wary of exposing juries to potentially confusing evidence and courts have recognized the inherent weight and persuasiveness the designation of "scientific evidence" can have in the minds of triers of fact. Bolstering that concern, some research suggests that as evidence becomes more complex and difficult to comprehend, jurors shift their focus to "peripheral indicia of reliability" (such as an expert’s qualifications or demeanor), and are more likely to defer to the expert’s opinion rather than forming their own.33 This deference to "scientific evidence" has been labeled by some courts as the "aura of infallibility."34 Furthermore, a few recent case reports of "wrongful convictions" based upon "questionable" or "unreliable" expert scientific testimony have exacerbated those concerns of juror over-reliance on "scientific evidence."35

While blind reliance on “scientific evidence/testimony” is a concern, empirical data does not support this contention.36 While many have judged the trilogy (Daubert, Joiner and Kumho) to be a laudable attempt to bridge the treacherous crosscurrents of Science and Law, numerous issues regarding the determination of “sound scientific testimony” have remained unanswered. For example, with regards to the “analytical gap” between research data and expert opinion addressed in Joiner, what is a sufficient amount and quality of evidence an expert may rely upon in bridging that “gap” in forming his/her opinion? Are medical textbooks (which are essentially expert treatises) authoritative references upon which experts may rely in forming their opinions? With regards to the “intellectual rigor” test of Kumho, what will be the applicable standard of professional practice to apply when, as often occurs in medical practice, multiple disciplines are involved? Who determines the applicable standard of professional practice? Individual experts? National Organizations? Additionally, some have echoed concerns about the onerous burden Daubert’s gate-keeping requirements have placed on the single trial judge.37 As the Honorable

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28 Id. at 1175.
29 Id. at 1176.
31 See J Kassirer and J Cecil, Inconsistency in Evidentiary Standards for Med-
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Judge Alex Kozinski of the Ninth Circuit Court of Appeals stated (once Daubert was remanded to the lower courts for reconsideration):38

Our responsibility, then, unless we badly misread the Supreme Court’s opinion, is to resolve disputes among respected, well-credentialed scientists about matters squarely within their expertise, in areas where there is no scientific consensus as to what is and what is not “good science,” and occasionally to reject such expert testimony because it was not “derived by the scientific method.” Mindful of our position in the hierarchy of the federal judiciary, we take a deep breath and proceed with this heady task.

Expectedly, the courts have grappled with some confusion in the face of such a complex task and responded with variable and inconsistent decisions. Some courts have attempted to reduce determinations of “sound scientific evidence” to simple “all or nothing rules” such as doubling the background rate of disease as proof and sometimes more demanding than actual medical practice.49

Current Medical Practice

If the objective of Law is Justice, then the objective of Medicine is to care for the patient. To truly understand the medical perspective, one must understand and accept the canon that Medicine is inherently, by its nature, an inexact science.50 There are aspects of Medicine (for example, “bench”, or laboratory, research) which are more “scientific” in nature. But the fields of Medicine that deal with direct patient interaction, also known as Clinical Medicine, are not exclusively “scientific”, especially if that means allowing only random field experiments to determine what is “scientific.” Much of science has been and will continue to be based on carefully documented observation. Human interaction inherently introduces variables (such as the nuances of effective communication and an individual’s behavioral, social, economic and cultural norms and biases) that are not readily reducible to empirical scientific data and yet these most certainly affect the outcome. The medical provider’s judicious interplay of the

38 See Kassirer and Cecil, supra note 49, at p. 1384, citing Daubert v. Merrell Dow Pharmaceuticals, Inc, 43 F.3d 1311, 1316 (9th Cir. 1995).
39 See Kassirer and Cecil, supra note 49, at p. 1384, citing Daubert v. Merrell Dow Pharmaceuticals, Inc, 43 F.3d 1311, 1316 (9th Cir. 1995).
40 Id, citing Jones v. US, 933 F. Supp 894, 897 (ND Cal 1996).
41 Id, citing Raynor v. Merrell Pharmaceuticals Inc, 104 F3d 1371, 1375 (DC Cir 1997).
47 See Cecil, supra note 38 at 75. This data is in contrast to one author’s assertion of judicial deference to admissibility of testimony on Abusive Head Trauma/Shaken Baby Syndrome. See Tuerkheimer, supra note 3, at pp. 42-47.
48 See Cecil, supra note 38 at 75. It is notable that the views of state courts is “less clear.” A 1998 survey of state court judges found that only 1/3 of judges believed the intent of Daubert was to raise the threshold of admissibility. See Id.
“human” variable with the “scientific” data of the human body is what has been termed by many as the “Art” of Clinical Medicine. It is important to understand that the designation of an “Art” is not a relegation to imprecision or lack of reliability. On the contrary, clinical medical decision making is grounded in the roots of the scientific method. As Dr. Mark McClellan, Co-Chair of the Institute of Medicine’s 2007 Annual Meeting, stated:53

Their (physicians) education includes the scientific basis of health and disease. They have been trained to use scientific literature to compare alternative approaches to diagnosis and treatment. They do their best to stay up-to-date through reading and conferences.

Additionally, physicians receive basic training on statistical analysis, often apply those principles to critically evaluate the medical literature, and sometimes pursue advanced degrees in statistical expertise (like biostatistics or epidemiology). While the cognitive underpinnings of the diagnostic process are rational and scientifically sound, ultimately, all diagnostic hypotheses represent probabilistic judgments that have variable probabilities of being correct.54 Furthermore, physicians are as susceptible as anyone to biases, preconceptions, or “intrusions of emotion,” any or all of which can influence clinical judgment and actions.55 Physicians can, and do, avoid, or at least minimize, errors in cognition by maintaining awareness of the pitfalls of heuristics (or “shortcuts” in problem-solving), and how personal biases and emotional temperature can affect them.56

But recent promulgations of an unsafe health care system have propagated fears that physicians have become less “scientific” in their daily clinical practice.57 Consequently, a movement for a greater emphasis on “evidence basis” in daily clinical practice has developed recently. “Evidence-Based Medicine” (EBM) has been characterized by one of its pioneers, Dr. David Sackett, as the “conscientious, explicit, and judicious use of current best evidence”58 in making decisions about individual care.”59 Dr. Harvey Fineberg, President of the Institute of Medicine, recently stated that, “the central notion in EBM is the importance of integrating individual clinical expertise with the best available external evidence. This will provide a helpful framework for providers to navigate the uncertainty inherent in patient care” (emphasis added).60

In fact, most healthcare providers strive to be “evidence-based” in their practice.61 Despite an increased focus on “evidence basis” in their practice, studies repeatedly show marked variability in what healthcare providers actually do in a given clinical situation.62 Many had hoped that EBM would provide “the” panacea for judicial discomfort over medical practice guidelines and interpretation of medical evidence. However, as the lingering controversies regarding mammography and prostate-specific antigen demonstrate, it has not been.63 Additionally, there are some areas of medicine, where the evidence is so sparse, that EBM simply cannot be instructive either for Medicine or Law.64

Ultimately, the physician must sagely balance his scientific knowledge, underscored by statistical data, his emotional temperature and potential biases, and the myriad complexities that make up the “human” variable. “Statistics cannot substitute for the human being before you; statistics embody averages, not individuals. Numbers can only complement a physician’s

53 See M McClellan, JM McGinnis, E Nabel, L Olsen, supra note 83, at. p.94.
54 See Henefkin, Kippen, Poulter, supra note 82, at p. 465.
56 Id.
57 See Institute of Medicine Report, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM. National Academies Press. (1999). The IOM reported that 44,000 to 98,000 patients die in American hospitals annually secondary to preventable medical errors (i.e., “technical” medical errors that could have been prevented had a more effective healthcare system been in place). While the IOM report focused primarily on “technical” medical errors, physicians have recognized the presence of cognitive errors that result in misdiagnosis or improper treatment and have endeavored to study the causes for such. See J Kassirer and R Kopelman, Cognitive Errors in Diagnosis: Instarnation, Classification, and Consequences, AM JOUR OF MED 86 (1989), pp. 433-441; P Croskerry, The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize them, ACAD MED 78 (2003), pp. 775-780; P Croskerry, Achieving Quality in Clinical Decision-Making: Cognitive Strategies and Detection of Bias, ACAD OF EMER MED 9 (2002), pp. 1184-1204.
58 The determination of what the “current best evidence” is in a given field requires a critical evaluation of the relevant medical literature, utilizing statistical principles to assess the validity of studies and the conclusions they reach. We will discuss basic principles of statistical analysis herein below when we critically evaluate the “current best evidence” in the field of Abusive Head Trauma.
60 Id.
63 See Kassirer and Cecil, supra note 49, at p. 1383.
64 Id.
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personal experience.”62 That is the “Art” of Clinical Medicine. Explicit evidence is only a portion of what physicians do.

Abusive Head Trauma (AHT) & the Medical Evidence

The peer-reviewed medical literature on the topic of AHT is voluminous. It is somewhat confusing how any author could assert there is a paucity of “quality” medical literature on the topic.63 In general, there have been two treatises,65 comprising more than 880 pages, on the topic of AHT. Additionally, there are three chapters,66 comprising another approximate 150 pages, on the topic of AHT within larger Child Maltreatment/Abuse texts. In addition to that, there are over 700 peer-reviewed, clinical medical articles,68 comprising thousands of pages of medical literature, published by over 1000 different medical authors, from at least 28 different countries69 on the topic of AHT. Furthermore, the topic of AHT has been examined, studied, and published in the following disciplines: biomechanical engineering, general pediatrics, neonatology, neurology, neurosurgery, nursing, obstetrics, ophthalmology, orthopedics, pathology (including forensic pathology), radiology, and rehabilitative medicine.

With regards to the “quality” of medical literature, there have been at least 8 systematic reviews, over 15 controlled trials, over 50 comparative cohort studies or prospective case series, and numerous well-designed, retrospective case series/reports, comprising thousands of cases, supporting the diagnosis of AHT.70 In all of the published, peer-reviewed, medical literature (greater than 700 articles), it is estimated that less than 5% of the clinical studies can be argued as “not supportive” of the diagnosis of AHT.71 Additionally, it is important to note that almost all of the papers questioning the validity of AHT (save one) are non-randomized, retrospective case series/reports, and without comparative control groups. In fact, several are single case reports.

In order to understand and appreciate the strength of the medical evidence surrounding AHT, some basic statistical concepts must be reviewed. In assessing statistical significance, it is important to understand the concept of the “p-value.” The “p-value” is “the probability of getting, just by chance, a test statistic as large as or larger than the observed value.”72 In more simple terms, it is probability that the result obtained is secondary to chance. In social sciences and medicine, this “observed significance level” (the p-value) is usually set at 5% (0.05) for “statistically significant,” or 1% (0.01) for “moderately high” statistical significance, and 0.1% (0.001) for “high or strong” statistical significance.73 Thus, if the p is smaller than 5% (0.05), the result is said to be “statistically significant.”74 Small p-values speak against the hypothesis that the result can be explained by chance, while large p-values indicate that chance cannot be ruled out as an explanation for the data.75

A few other statistical concepts in clinical medicine are important to discuss briefly: “sensitivity,” “specificity,” “positive predictive value,” by Sandeep Narang, MD/JD

69 See Groopman, supra note 82, at p. 6.
71 The restricted searches to the search terms “subdural hemorrhages” and “retinal hemorrhages” by themselves produced over 1000 abstracts and over 500 abstracts, respectively. This author then reviewed over 1000 abstracts from the above searches to gauge applicability to the topic of Abusive Head Trauma, and safely determined that at least 700 articles were pertinent to the topic.
72 The different nationalities publishing on this topic include: Argentina, Australia, Belgium, Brazil, Canada, China, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, India, Israel, Italy, Japan, Malaysia, Netherlands, New Zealand, Norway, Poland, Russia, Singapore, Spain, Sweden, Switzerland, United Kingdom, and the United States.
74 Id. See also Watstones v. Port Auth., 948 F.2d 1370, 1376 (2d Cir. 1991) at 1376; (“Social scientists consider a finding of two standard deviations significant, meaning there is about one chance in 20 that the explanation for a deviation could be random…”); Rivera v. City of Wichita Falls, 665 F.2d 531, 545 n. 22 (5th Cir. 1982) (“A variation of two standard deviations would indicate that the probability of the observed outcome occurring purely by chance would be approximately two out of one hundred; that is, it could be said with a 95% certainty that the outcome was not merely a fluke.”)
75 Id. Computing the p-value requires statistical experience and is reserved for those with expertise in statistics and epidemiology.
76 Id at p. 172.
and “negative predictive value.” “Sensitivity” is the probability that a test for a disease will give a positive result when the patient actually has the disease.77 Put simply, it is actually the chance the condition will be found by the test. “Specificity” is the probability that a test for disease will give a negative result when the patient does not have the disease.78 Put simply, it is the chance that someone without the disease will actually have a negative test. “Positive Predictive Value” is the proportion of patients who have positive test results and actually have the disease/condition. This value is very important in diagnostic testing as it reflects the probability that a positive test reflects the underlying condition being tested. “Negative Predictive Value” is the proportion of patients with negative test results who are correctly diagnosed.

Prior to comprehensively examining the statistical medical literature on two common injuries found in AHT — subdural hemorrhages (SDH’s) and retinal hemorrhages (RH’s), it is relevant to examine one piece of medical literature which is often cited by opponents79 of AHT as evidence of the paucity of sound medical literature on AHT (SBS): “Evidence-Based Medicine and Shaken Baby Syndrome Part 1: Literature Review, 1966-1998.”80 In this four page article, the author purports to comprehensively examine all the published, peer-reviewed medical literature on AHT from 1966-1998. Based upon the author’s search of just one medical database (the Medline database), and the Internet via “Internet Explorer”, using only the search term “shaken baby syndrome”, the author finds only 71 articles (in a span of 32 years of medical literature) on the topic of AHT (SBS).81 Based upon the author’s review of 54 of the 71 articles, the author finds “only 1 randomized control trial” and 26 case series (25 retrospective and 1 prospective), and a total of 307 cases of SBS.82 The author thereafter concludes that there exist “serious data gaps,” “flaws of logic,” and “inconsistency of case definition” in SBS, catch-phrases which have been frequently “refied” in some medical and legal literature.83 Consequently, the author concludes that “the commonly held opinion that the finding of SDH and RH in an infant was strong evidence of SBS was unsustainable, at least from the medical literature.”84

This article is a prime example of poor medical literature, which somehow makes its way into a medical publication. It is unclear why, and unacceptable that, the author chose to conduct his search with only one medical database and with a confining search term such as “shaken baby syndrome.” The author fails to utilize other common terms such as “Inflicted Neurotrauma,” “Non-Accidental Trauma,” “Whiplash Shaken Infant/Baby Syndrome,” or even more general terminology such as “Subdural Hemorrhage/Hematoma” or “Retinal Hemorrhage.” Because of this methodological flaw, as will be demonstrated below, the author misses the vast majority of literature on AHT.85 Additionally, the author offers no critical analysis of any of the articles cited, no assessment of the designs of any of the individual studies, no reference to the statistical information, and, no analysis of any of the statistical data or the inferences drawn from them. Finally, the author improperly assigns “quality of evidence ratings” to a diagnostic, not therapeutic, scenario. It is troubling that legal scholars86, and some courts87, have relied upon this article as an adequate assessment of the medical literature surrounding AHT. Any future reliance upon this article should be seriously questioned.

A. Subdural Hemorrhages

The differential diagnosis (i.e., list of potential causes) for subdural hemorrhages (SDH’s) is extensive. It can include trauma, infection, metabolic/genetic disorders, bleeding disorders and malignancy, to name a few. As will be demonstrated via the medical literature below, the most common cause of SDH’s is trauma. When traumatic, the mechanism for the SDH is either a contact (or impact) force, an inertial (acceleration-deceleration) force, or both.88 Contact forces cause damage at the site where contact occurs. Disruption of the skull’s integrity secondary to the contact force can result in a disruption of the underlying blood vessels and

77 Id at p. 172.
78 Id at p. 173.
79 See Tuerkheimer, supra note 1; Gena, supra note 1.
80 See Donohoe, supra note 1.
81 Id at p.240.
82 Id.
83 Id at p. 241. See also Tuerkheimer, supra note 1, at p. 16.
84 Id.
85 In fact, in the article itself, the author admits missing what he himself considers an “important” study by Jayawant et al.” using his own search criteria. See id at p. 240.
86 See Tuerkheimer, supra note 1; Gena, supra note 1.
87 See State v. Edmunds, 2008 WI App 33 (Wisconsin Court of Appeals grants the defendant/appellant a new trial on the basis that defendant presented “newly discovered evidence” of a “significant and legitimate debate in the medical community” regarding Shaken Baby Syndrome, which has emerged in the past 10 years).
88 See, L.Rorke-Adams, supra note 3at p. 61.
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consequent development of a hematoma/hemorrhage. These hematomas/hemorrhages can be epidural (outside the dura mater), subdural (in the potential space underneath the dura mater), or, sometimes, intradural (within the layers of the dura). In inertial events, the acceleration-deceleration motion of the brain results in strain upon the cortical bridging veins which exceeds their tolerance levels and subsequently leads to rupture and hemorrhage (subdural and/or subarachnoid). Several studies indicate that trauma is the most common cause. In one such prospective study of all infants age 0-2 in the U. K. and the Republic of Ireland, from 1998-1999, Hobbs et al. identified 186 infants with SDH’s (by CT, MRI, Ultrasound, or post-mortem examination). Of the 186 infants with SDH’s, 113 (61%) were caused by trauma, 30 (16%) by infection or other non-traumatic medical cause, and 43 (23%) were undetermined. Of the 113 traumatic SDH’s, 106 (94%) were determined to be of Non-accidental etiology and only 7 (6%) were determined to be accidental. Similar results were noted in retrospective reviews by Jayawant et al. in Wales & southwest England from 1993-1995, Trenchs et al. in Barcelona, Spain from 1995-2005, and Tzioumi & Oates in the Royal Alexandra Hospital for Children in Australia.

Pathology studies have also confirmed the predominance of trauma, and more specifically Non-Accidental Trauma, as the cause of SDH’s. In 2009, Matschke et al. published the results of their 50 year retrospective review of the causes of death for infants less than two years old. Of 715 infant deaths, only 50 infants (7%) were identified with SDH’s. Of those 50 SDH’s, 15 (30%) were traumatic, 13 (26%) were secondary to bleeding/clotting disorders, 13 (26%) were perinatal, 4 (8%) were infectious, 4 (8%) were undetermined, and 1(2%) was secondary to metabolic disease. Of the traumatic SDH’s, 14 (93%) were secondary to Non-Accidental Trauma, and only 1 (7%) was accidental. Thus, Matschke et al. concluded that “most SDH’s are attributable to trauma, with NAHI [Non-Accidental Head Injuries] substantially outnumbering accidental injuries.”

Although SDH’s are not specific for Non-Accidental Injury, several well-designed prospective studies demonstrate a significant and strong association of SDH’s with Non-Accidental Inflicted Trauma over Accidental Trauma. In 1992, Duhaime et al. published the results of their prospective study of 100 patients less than 2 years of age who suffered head injuries. In efforts to avoid “circularity” concerns, Duhaime et al. used strict criteria for determining “inflicted” injury. The authors excluded retinal hemorrhages (RH’s) as a diagnostic criteria and only included SDH’s that had no history of trauma, but had clinical or radiologic findings of blunt impact to the head. Thus, the authors designed an algorithm which was “deliberately biased to reduce false positives and thus underestimate the true incidence of child abuse.” In Duhaime et al.’s cohort, 76 patients were determined to be from accidental causes and 24 were determined to be “inflicted.” Duhaime et al. found that only 6/76 (8%) patients in the accidental group had SDH’s, while 13/24 (54%) patients in the “inflicted” group had SDH’s. This computed to a “P- value” of less than .0002. In understanding the “P-value” another way, this means that these findings could have occurred by chance/randomly no more than 2 in 10,000. Thus, Duhaime et al. concluded that the relationship between inflicted injury and SDH’s was highly statistically significant. In 2004, this hypothesis was re-tested and Bechtel et al. produced similar results.

In 2010, Vinchon et al. published the results of their prospective series of 84 patients, from 2001 to 2009, with independent corroboration of

96 This author would argue that a certain portion of “perinatal” SDH’s could be argued as traumatic, as the literature documents an association of SDH’s with the birthing process or birth trauma.
97 Id. at p. 180.
99 Id at p. 637-45.
100 Remembering “P-values” from the general statistical principles section above, P-value is essentially the likelihood the result is due to chance.
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Similar results were produced by Hymel et al.\textsuperscript{104} and by Datta et al.\textsuperscript{105} Additionally, in the Datta et al. study, there was a statistically significant association with multifocal SDH’s and Non-Accidental Injury.

Thus, with regards to the validity and reliability of the statistical evidence on SDH’s and AHT, there are several well-designed prospective studies and retrospective reviews. Additionally compelling is that the statistical results are similar along multiple lines of research—pathology, radiology and general pediatrics. \textit{All have produced the same results: the significant statistical association of SDH’s with Non-Accidental Trauma over Accidental Trauma.} This author’s review of the evidence-based medical literature has revealed no published, peer-reviewed clinical studies that conclude differently.

\textbf{B. Retinal Hemorrhages}

Hemorrhages can occur on the surface of the retina ( preretinal ), under the retina ( subretinal ), or within the retinal layers ( intraretinal ). Hemorrhages can have a certain appearance and size, and can be confined to the posterior pole ( an area of the retina near the optic disc, optic vessels and optic nerve ) or extend to the ora serrata ( the edges of the retina ).\textsuperscript{106} “Flame” or “splinter” RH’s are hemorrhages that lay in the superficial nerve fiber layer of the retina.\textsuperscript{107} “Dot” and “blot” RH’s are round and amorphous-shaped hemorrhages within the deeper layers of the retina.\textsuperscript{108} An important form of RH’s is retinoschisis — where there is splitting of the retinal layers with blood accumulating in the intervening space.\textsuperscript{109} Retinoschisis can sometimes be accompanied by circumlinear pleats or folds in the retina at the edges of the schisis.\textsuperscript{110} Retinoschisis with pleats or folds is an important finding because, other than Abusive Head Injury, in children younger than 5 years, it has only been reported in two cases of fatal crush injuries to the head, one case of leukemia, and in cases of severe, fatal motor vehicle accidents.

Mild RH’s are generally understood to be a few, dot/blot or flame/splinter-shaped RH’s, in the intraretinal or preretinal layers, and confined to the posterior pole.\textsuperscript{111} Severe RH’s are generally understood to be diffuse, too numerous to count hemorrhages, extending to the periphery of the retina ( not confined to the posterior pole ), usually involving multiple layers of the retina (intraretinal, preretinal or subretinal ), and sometimes accompanied by retinoschisis with or without folds.\textsuperscript{112}

As with SDH’s, the differential diagnosis for subdural hemorrhages RH’s is extensive. It also includes trauma, infection, metabolic/genetic disorders, bleeding disorders and malignancy, to name a few. Through the inferential and

\textsuperscript{103} See Wells RG; Vetter C; Laud P. Intracranial hemorrhage in children younger than 3 years: prediction of intent. \textit{Arch Pediatr Adolesc Med} 2002 Mar;156(3):252-7.


\textsuperscript{107} Id.

\textsuperscript{108} Id.

\textsuperscript{109} Id.

\textsuperscript{110} Id.

\textsuperscript{111} Id.

\textsuperscript{112} Id.
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deductive process of eliminating other potential mechanisms, one recognizes the significant probability that repetitive acceleration-deceleration forces are the causative mechanism of severe RH's.

While several studies demonstrate an association of RH's with birth, several factors distinguish birth-related RH's from the RH's commonly seen in AHT. First, the vast majority of birth-related retinal hemorrhages are intra-retinal (within the layers of the retina). Multi-layered RH's, as commonly seen in AHT, have not been reported in the medical literature in association with birth. Second, study of the natural history of birth-related RH's reveals that the vast majority of these RH's resolve by two to four weeks of life. This led one author to conclude that RH's in infants older than 1 month “are not likely related to birth.” Finally, retinoschisis (splitting of the retina) has never been reported in association with birth injury.

The commonality, and somewhat similarity, of birth-related RH's and the RH's commonly seen in AHT compels one to consider increased intracranial pressure or increased intrathoracic pressure as potential causative mechanisms for RH's. Additionally, because rib fractures are occasional concurrent injuries in AHT cases, increased intrathoracic pressure is naturally thought to be implicated.

However, studies examining the effects of chest compressions in CPR (cardio-pulmonary resuscitation) have failed to demonstrate any severe RH's (the kind seen in AHT). In one such study, Odom et al. prospectively examined the prevalence and character of RH's in patients in a pediatric ICU that had received at least 1 minute of chest compressions and survived. After excluding patients that had evidence of trauma, documented retinal hemorrhages before CPR, suspicion of child abuse, or diagnosis of near-drowning or seizures, Odom et al. found 43 patients that met inclusion criteria. In fact, all of the precipitating events leading to cardiopulmonary arrest occurred in their intensive care unit, eliminating the possibility of physical abuse as an etiology. Of the 43 patients, the mean duration of chest compressions was 16 minutes, with 58% lasting between 1 and 10 minutes. Five patients had chest compressions lasting >40 minutes, and two patients had open chest cardiac massage. All of the patients survived their resuscitative efforts. Odom et al. found small punctate retinal hemorrhages in only one patient. There was no patient with severe RH's.

Well-designed studies involving other clinical scenarios that increase intrathoracic pressure, e.g., coughing, vomiting, or seizures, also have failed to demonstrate any of the type of RH's (severe) commonly seen in AHT.

With regards to increased intracranial pressure as a cause for severe RH's in children, in 2002, Schloff et al. published the results of a prospective study which was designed to find the incidence of RH's in children with increased intracranial pressure and intracranial pressure (also known as Terson's syndrome). Only children from known non-abuse cases were included in their study. Of the 57 children studied, 27 were from known accidental trauma (MVAs, sports accidents, falls, etc.), 24 from surgeries, and 6 from other causes (vessel malformations, infection, etc.). 55/57 (96%) had no evidence of RH. One child had a single dot hemorrhage associated with presumed infection. The second child had three flame and two deeper dot intraretinal hemorrhages. She was the victim of a motor vehicle accident. No child had severe or multi-layered RH's. These results accord with the retrospective review conducted by Morad et al., also published in 2002.

Furthermore, the postulated mechanism of RH's in the setting of increased intracranial pressure—obstruction of venous outflow from the

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113 Id.
114 Id.
115 Id. There are rare cases of birth-related RH's lasting until six to eight weeks of life. There has been no documentation of birth-related RH's outside of eight weeks (2 months) of life.
117 See Levin, supra note 41.
118 Id.
119 Id.

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eye (i.e., blood flowing out of the eye, through the head, and back towards the heart) produces a pattern of hemorrhages that is not the pattern of hemorrhages seen in AHT.\(^{126}\) The accidental head injury\(^{127}\) literature also demonstrates no severe RH’s, and many of the children in those studies experienced increased intracranial pressure. On the other hand, several lines of research and analysis point towards acceleration-deceleration forces at the vitreo-retinal interface.\(^{128}\) First, the anatomy of the infant retina is different than in adults — vitreous gel in infants is much more adherent to the retina than in adults. Along those lines, the pattern of hemorrhages in severe RH’s correlates with the anatomy of the eye in the young child where the vitreous is most adherent with blood vessels.\(^{129}\) Second, severe RH’s are not commonly seen in single acceleration-deceleration traumatic events (MVA’s, falls).\(^{130}\) Third, in fatal cases, postmortem studies reveal that the vitreous is often still attached at the top of retinal folds, indicating a traction mechanism.\(^{131}\) Finally, as will be detailed below, there is an extremely high statistically significant association of severe RH’s with AHT.

In 2010, Vinchon et al.\(^{132}\) also examined the eyes of infants who had independent corroborative evidence of head injury. In their prospective series of 84 patients who sustained injuries from either witnessed accidents (N=39) or confessed inflicted head injury (N=45; obtained from judicial sources), of the 39 witnessed accidents, only 1 patient (2.5%) had moderate or severe RH’s—that patient had known impact to his head. Of the 45 confessed inflicted injury patients, 34 (76%) had moderate or severe RH’s. Conversely, 34/39 (87%) accident patients had mild or no RH’s; and, 10/45 (22%) of the inflicted head injury patients had mild or no RH’s. This data is graphically depicted in Figure 1. This computed to a “p-value” of less than .001 (0.1%). In further statistical analysis, Vinchon et al. determined the specificity and positive predictive value of severe RH’s for abusive injury to be 97% and 96%, respectively. Thus, Vinchon et al. concluded that, in the absence of ocular impact, severe RH’s was specific for inflicted head injury. Similar results have been produced in well-designed prospective studies by Pierre-Kahn et al.\(^{133}\) and Bechtel et al.\(^{134}\) Pathology studies have produced similar results.

\(^{126}\) See Levin, supra note 41, at p. 338.

\(^{127}\) See Trenchu V, Curtoy AI, et al. Retinal haemorrhages in- head trauma resulting from falls: differential diagnosis with non-accidental trauma in patients younger than 2 years of age. Childs Nerv Syst. 2008 Jul;24(7):815-20. When RH’s were present, there were only a few preretinal or intraretinal RH’s confined to the posterior pole in up to only 3% of cases.

\(^{128}\) See Levin, supra note 41 at p. 338.

\(^{129}\) Id.

\(^{130}\) Id.


\(^{132}\) See Vinchon, supra note 37.


\(^{134}\) See Bechtel, supra note 36.
Results. Riffenburgh\textsuperscript{135} studied 197 confirmed child abuse deaths and compared them to 401 controlled patients (deaths secondary to auto accidents, drowning, SIDS). Riffenburgh found 47\% of child abuse deaths had RH’s whereas only 4\% of controls had RH’s. This computed to a “P-value” of less than .001 (0.1\%), and an odds ratio of 18.9 for RH’s and abuse. Other authors have published comparable findings.\textsuperscript{136} In 2009, Maguire et al.\textsuperscript{137} published the results of their systematic review of all the scientific literature to identify clinical features that distinguished inflicted from non-inflicted brain injury. After reviewing 20 electronic databases, websites, references and bibliographies, using over 100 keyword combinations, Maguire et al. identified over 8000 studies which were relevant to the topic, and reviewed 320. Secondary to strict inclusion criteria (including only those studies that compared the clinical features of inflicted and non-inflicted brain injury with consecutive case ascertainment), Maguire et al. found 14 studies that met those criteria, representing over 1600 children. The authors specifically excluded all studies where the decision of abuse relied solely on clinical features, so as to eliminate concerns for “selection bias” and “circularity.” Conducting a multi-level logistic regression analysis, Maguire et al. found that RH’s were “strongly associated with inflicted brain injury, with a positive predictive value of 71\% and an odds ratio of 3.5.”\textsuperscript{138} The author’s concluded that “by producing a multilevel logistic regression of specific clinical features on over 1600 children, we have shown that there is scientific evidence to support the distinction between inflicted brain injury and non-inflicted brain injury…” This review is the largest of its kind, and offers for the first time a valid statistical probability of inflicted brain injury when certain key features are present (eg, retinal hemorrhages)\textsuperscript{139} (emphasis added).\textsuperscript{139} Similar results were produced in another systematic review by Bhardwaj et al. in 2010.\textsuperscript{140} Thus, again, with regards to validity and reliability, there are two systematic reviews (comprising over 30 well-designed clinical studies and thousands of children), several, well-designed prospective studies, numerous retrospective reviews, from multiple lines of research — general pediatrics, ophthalmology, and pathology — all which have produced the same results: the highly significant statistical association of severe RH’s with AHT. In his review of the evidence based medical literature, Dr. Narang found no published, peer-reviewed clinical studies that concluded differently.\textsuperscript{141}

\textsuperscript{138} Id. at p.865.
\textsuperscript{139} Id.
\textsuperscript{140} See Bhardwaj G, Chowdhury V et al. A Systematic Review of the Diagnostic Accuracy of Ocular Signs in Pediatric Abusive Head Trauma. Ophthalmonology. 2010 Mar 26. (The author’s commented that “combined data from prospective studies of head injury indicate that IOH [intraocular hemorrhages] have a specificity of 94\% for abuse.”)
\textsuperscript{141} Dr. Narang’s review was completed during the spring of 2010.

Questions that a qualified pediatric child abuse specialist can answer that might help the trier of fact in a civil or criminal trial

Currently, it is not possible to scientifically establish, based only on a physical examination, to the minute when a child received an arm fracture, a subdural hematoma or a skull fracture. It is possible to answer to a reasonable degree of medical certainty based on radiation images whether two fractures to the long bones of the same child are acute or older fractures. It is possible to answer with a reasonable degree of medical certainty using CAT scans and MRI’s whether there is bleeding in the brain that is quite recent or quite old. It is not possible to determine the exact force in ergs or foot pounds what pressure was exerted with what vectors of force to cause a specific fracture or bleed based only on the nature of the injury being observed. It is possible and medically justified to testify whether the history of a child’s reported fall is, or is not, a plausible explanation for the fatal injuries later documented, for example through an autopsy.\textsuperscript{142}

Questions that a qualified medical expert can usually answer with clarity and accuracy include:

- Do all cases of suspected inflicted head trauma also have associated retinal hemorrhages?
- Can retinal hemorrhages occur when there is no inflicted head injury?

Questions that a qualified medical expert usually cannot answer with precision include:

- Did this subdural hematoma occur at a specific time?
- How old are these retinal hemorrhages?
- What is the exact mechanism that caused the injury to this child’s brain?
- What are the exact forces that produced the observed injury to this child’s brain?

An example of a question that can create difficulty for a less experienced physician is: “Wouldn’t you expect that if a child had been violently shaken or suffered a impact sufficient to cause this injury, that there would be spinal injuries that could be observed? “The most scientifically informed answer is that: “Intuitively, we would expect such findings, and in some cases spinal injuries are documented. However, for reasons not yet documented in the scientific literature such spinal injuries are not always found even when there are other clear indications of AHT.” This is another example of why the use of the word “syndrome” often appears in medicine. It means that certain signs and symptoms commonly occur together, but do not necessarily always occur in a given condition. This is similar to the observation that in many cases, but not all, retinal hemorrhages are found when AHT is diagnosed.

Conclusion

Robust and widely supported science exists for the diagnosis and treatment of abusive versus non-abusive head trauma. The same science supports testimony that is completely admissible under and worthy of full evidentiary consideration under American statutory and case law.

At the present time, objections based on articles published in peer reviewed journals, whether law journals or science journals, questioning the diagnosis of AHT, can only imply that further research could be used to justify or rebuff assumptions made by critics about the precise dynamics of AHT. For example, there is one reported case of a videotape of a short distance fall where the child was quickly brought to the hospital and suffered a fatal injury. Specific research that proves that this is a common occurrence has not been published, and indeed published research suggests such events are quite rare (much less than one in one million).143 Certainly there is no random field experiment that shows that children can suffer injuries that appear to be caused by AHT when the injuries are actually being caused by some other “accidental” means. Such experiments cannot be done ethically.

The most important current trial advocacy task for lawyers presenting cases of AHT in court is to emphasize clarity in the statement of the case and questions to witnesses. The next step is to be prepared to cross examine critics about the limited science being used in an attempt to create doubt that there is any objective basis for diagnosing Abusive Head Injury under the facts available.


A Review of the Medical and Legal Literature on Abusive Head Trauma: Trial Advocacy Implications

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Dependency / ICPC


SUMMARY BY NACC LEGAL INTERN ELLEN PEPPER, JD CANDIDATE, UNIVERSITY OF COLORADO LAW SCHOOL.

D.M., born in 2005, resided with his mother until 2008 when he was placed in protective custody based on allegations of neglect, domestic violence, and drug use. The Department of Social Services (the Department) filed a dependency petition, and the juvenile court ordered that D.M. be placed with a foster family.

At the time of the dependency proceedings, the Department did not know where the father resided, and he had not been served with the dependency petition. When Father learned that D.M. was in foster care, he contacted the Department to express his desire to have his son placed with him.

Father was living in Oklahoma and the proceedings took place in Washington. Therefore, the Department requested that Oklahoma do a home study on Father under the Interstate Compact on the Placement of Children (ICPC). After the home study, Oklahoma refused supervision on the grounds of inadequate housing. Father lived with his mother in a two-bedroom house, which was inadequate under Oklahoma policy because there were only two bedrooms for three people.

The Department believed Father to be a fit parent but stated that without a positive ICPC home study it was not lawful for the court to place D.M. with Father in Oklahoma. The court disagreed and ordered D.M. to be placed with Father. D.M.’s mother requested discretionary review and the Washington Court of Appeals granted her request.

The issue before the Washington Court of Appeals was whether the ICPC applies to parental placements. The ICPC, a matter of state law, is statutory and contractual. The court began by stating that the primary goal when interpreting statutes is to determine the intent of the legislature. The ICPC’s purpose is to “foster cooperation and information sharing among member states so as to ensure that children requiring placement receive the maximum opportunity to be placed in a suitable environment.”

Article III of the ICPC limits the scope of the compact to placements in foster care or placements preliminary to an adoption. Courts are divided on whether the ICPC applies to out-of-state placement with a parent. Some courts hold that the ICPC does apply to such placements, relying on Article VII and X of the ICPC. Article X states that the ICPC’s provisions should be liberally construed to effectuate its purposes. Article VIII sets out certain situations that should be excluded from the compact. Article VIII does not mention parental placements as an exception. Due to the lack of clarity, with one article indicating the ICPC must be applied liberally and the other not having an exception for parental placements, some courts have determined that the ICPC applies to such placements.

The Washington Court of Appeals disagreed with such reasoning because it conflicts with the plain terms of article III which “limits the scope of the compact to foster care or preadoption placements.” Based on the plain language of the statute, the court held that the ICPC does not govern parental placements.

The court then addressed the regulation that the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) had issued, which states that the ICPC governs parental placements, with some exceptions. Washington has not adopted the AAICPC regulations and therefore the regulation is not
binding. Further, the court determined that the AAICPC regulation expands the scope of the ICPC beyond its original scope as stated in article III.

The court emphasized that ultimately courts are the decision-makers as to whether placement with a parent serves the best interests of the child, not administrative agencies. The AAICPC’s regulation gives the administrative agency in a sister state complete control over the placement even when the court has determined the parent is fit.

The court held that the AAICPC’s regulation impermissibly expands the ICPC as set out in article III and that the ICPC does not require sister state approval of parental placements. The court then held that the juvenile court did not err when placing D.M. with his father in Oklahoma.

Dependency / Constitutional Law

SUMMARY BY NACC LEGAL INTERN DONALD ANDREW YOST, JD CANDIDATE, SUFFOLK UNIVERSITY LAW SCHOOL.

After allegations surfaced that Mr. Greene sexually abused his daughters, S.G. and K.G., the Oregon Department of Human Services (DHS) assigned caseworker Camreta to assess the girls’ safety.

Without a warrant or court order equivalent, Camreta and police officer Alford visited S.G.’s elementary school and interrogated S.G. for two hours. After initially denying any abuse, S.G. eventually stated that her father had abused her. Camreta later visited Mr. Greene and his wife, Mrs. Greene, who both denied any abuse. The parents nevertheless agreed to adopt a safety plan requiring S.G. to undergo a sexual abuse examination.

Mr. Greene was later indicted on the assault charges and ordered not to have any contact with his daughters. Camreta visited the Greenes to inform them of the order. In conflicting versions of the facts, Mrs. Greene allegedly told Camreta that Mr. Greene would live outside the home, though it would be a financial hardship. She also said she would accompany her children to the medical examination. According to Camreta, however, Mrs. Greene stated she could not afford alternative housing for Mr. Greene and refused to sign a release permitting the examinations.

Fearing for the children’s safety, Camreta petitioned the court for protective custody on the grounds that Mrs. Greene refused to comply with the safety plan. The court issued a protective custody order and the girls were removed from the home.

Thereafter, S.G. and K.G underwent medical exams. Mrs. Greene attempted to accompany her daughters to the exam, but Camreta excluded her from the premises. The examinations were inconclusive as to abuse and the children were returned to Mrs. Greene’s custody. Eventually Mr. Greene stood trial and the court dismissed the charges.

The Greenes filed suit against Camreta, alleging the following: (1) Camreta’s warrantless, in-school seizure of S.G. violated her Fourth Amendment rights, (2) Camreta infringed Mrs. Greene’s Fourteenth Amendment rights by intentionally presenting false information to the court regarding her willingness to comply with the safety plan, and (3) Camreta violated Mrs. Greene’s fundamental right to familial autonomy by excluding her from her children’s examinations.

The district court granted summary judgment on all issues. The Greenes appealed.

The circuit court first considered the Greenes’ Fourth Amendment argument. Under the Fourth Amendment, individuals have a right against unreasonable searches and seizures by the government. A seizure is generally reasonable where there is probable cause and a warrant, or exigent circumstances. In some limited cases however, Fourth Amendment jurisprudence provides for bypassing the warrant-standard and performing a lowered, context-specific analysis of “reasonableness.” This requires examining
the particular circumstances of the search and seizure. Traditional Fourth Amendment protections are lowered only if there is a “special need” beyond that of normal law enforcement. Notably however, even when government officials violate an individual’s constitutional right to unreasonable search and seizure, qualified immunity precludes civil liability so long as the official’s actions were not a violation of clearly established constitutional rights of which a reasonable person would have known.

Camreta argued that because S.G.’s seizure occurred at school rather than home and involved potential child abuse, a special standard of reasonableness applied. The court rejected this argument, stating that only very limited circumstances justify varying the reasonableness standard in a school context, such as when a school official (not a government official) must perform a search to maintain discipline. Where the seizure involves a criminal element and is performed by caseworkers or other government officials, even in the face of child abuse allegations, the traditional reasonableness standard applies.

Camreta argued that because S.G.’s seizure involved a law enforcement element with the interview, thus requiring the appropriate and traditional procedural safeguards.

Finally, Camreta asserted qualified immunity, stating even if he infringed S.G.’s constitutional rights he cannot be held civilly liable because he reasonably believed S.G.’s seizure was justified at its inception. The court agreed, reasoning that what constituted an unreasonable seizure at a school in light of alleged child abuse was not clearly established in prior case law sufficient to put Camreta on notice that his actions violated the Fourth Amendment. The court also noted his conduct was within the scope of reasonable action given the circumstances. Importantly, the court cautioned government officials against the assumption that “special needs” or child abuse allegation automatically justifies bypassing traditional Fourth Amendment protections.

Thus, the circuit court held the general law of search warrants (or a court order equivalent) applies to child abuse investigations to permit the seizure and interview of a child at school in a criminal context. However, the court also held Camreta could have reasonably, though mistakenly, believed S.G.’s seizure was justified, entitling him to qualified immunity.

The circuit court next considered the first of the Greenes’ two Fourteenth Amendment challenges. Under the Fourteenth Amendment, individuals are guaranteed the right to procedural due process of law, including the right to be free from perjured evidence.

The circuit court reversed the Greenes’ procedural due process claim. Lastly, the court considered the second Fourteenth Amendment challenge stemming from Camreta’s exclusion of Mrs. Greene from her daughters’ examinations. In addition to procedural due process, the Fourteenth Amendment guarantees that an individual’s fundamental right to familial autonomy shall not be infringed absent a compelling state interest. This includes a mother’s right to be present when her children face potentially traumatic events.

The circuit court recognized that Greene was entitled to this right and found prohibiting Mrs. Greene from accompanying her daughters to their examinations and preventing her from waiting for them in an adjacent room absent a valid reason violated her constitutional rights.

Thus, the Ninth Circuit Court of Appeals held, pursuant to the Fourth Amendment, a reasonable search and seizure in a child abuse investigation generally requires probable cause and a warrant before a child can be interviewed by a government official at school. Additionally, a government official is entitled to qualified immunity so long as the constitutional right they violated was not clearly established and they violated it with the reasonable belief that their actions were sufficiently justified and reasonable within the scope of the circumstances. The court emphasized government officials should not
operate on the assumption that they may jettison Fourth Amendment protections in child abuse cases under the “special needs” doctrine. Finally, the court reaffirmed the Fourteenth Amendment guarantee that parents have the right to be present when their children undergo medical examinations, as well as the right to be free from perjured evidence under due process of law.

The United States Supreme Court granted certiorari. The case is now pending.

Dependency / Termination of Parental Rights


Summary by NACC Legal Intern Anna Reinert, JD Candidate, University of Denver Sturm College of Law.

The father of J. and C. appealed from a decision terminating his parental rights while he was in prison, claiming, in part, that termination was premature because the trial court had not considered the children’s placement with relatives or properly evaluated whether placement with him could be appropriate in the future.

Father was jailed for drunk driving in October 2006, shortly before C. was born. Prior to this time, he worked construction to provide support to J. and J.’s mother (“Mother”). Mother brought the children to visit Father every week while he was in jail.

In June 2007, DHS removed the children from Mother’s care. The removal petition alleged that Father had also neglected the children by not providing for their physical, emotional and financial needs. At a hearing in August 2007, that Father did not participate in, the trial court adopted a service plan for both parents, and placed the children with Father’s family at Mother’s request.

At the time of Father’s anticipated release in August 2007, his incarceration was extended because his drunken driving conviction violated the conditions of his probation. He was sentenced to prison until at least July 2009. The court restricted Father’s contact with the children to cards and letters. Father was not notified of his right to participate in future hearings by telephone. In fact, he did not participate in the proceedings again until December 2008 when a permanency planning hearing was held.

At the permanency planning hearing, DHS sought termination of parental rights based on the parents’ failure to meet the conditions of their service plans, and the fact that the children had already been in care for almost 18 months.

At the February 2009 termination hearing, Father opposed termination based on his anticipated release in July 2009, completion of educational courses, attendance of Alcoholics Anonymous meetings, passage of a drug test, and paid work while in prison. Father was also on a waiting list for parenting classes and counseling, but as a prisoner could not request a psychological evaluation. Additionally, Father had arranged a construction job with his brother and housing with his mother after his release.

Despite his efforts, the trial court terminated Father’s parental rights. The court found that he had not personally cared for the children in the last two years; due to his incarceration, he could not take advantage of DHS services, and that according to DHS it would take an additional six months to comply with the service plan and parole conditions after his release.

After the appellate court affirmed the trial court, Father appealed to the Supreme Court of Michigan. The supreme court found that the trial court erred by effectively terminating Father’s parental rights based solely on his present inability to personally care for his children.
because of his incarceration. The court reasoned that the trial court had failed to correctly apply relevant statutes and had based its decision on a record that was not fully developed because the state had not involved Father in the proceedings. The court found that the trial court specifically failed to understand that each statutory element must be met before a court can order termination. This meant that although Father was in prison he did not have to personally care for the children in order to preserve his parental rights. The trial court erred by not recognizing the great weight against termination that is created when children are placed with relatives.

Moreover, the trial court did not evaluate Father’s ability to provide proper care to his children in the future. The court only considered Father’s inability to provide care while he was in prison. Yet, the court found that Father had not only remained in contact with his sons, but had also engaged in activities that amounted to compliance with parts of the service plan while he was in prison.

Finally, the trial court based its decision on a record that was largely undeveloped. DHS offered nothing more than Father’s criminal history to establish that the children would be harmed if they lived with him after his release. The court found that neither a person’s incarceration nor his criminal history alone can justify termination.

The Supreme Court of Michigan reversed the termination judgment and remanded the case to the trial court.

Dependency / GAL Representation

Although Guardian Ad Litem’s Recommendations Conflicted with Children’s Wishes, Court Held Children Did Not Need Attorney to Represent Their Wishes. In re M.C., 2010 WL 1223938 (Ohio Ct. App. 2010).

SUMMARY BY NACC LEGAL INTERN ELLEN PEPPER, JD CANDIDATE, UNIVERSITY OF COLORADO LAW SCHOOL.

In April of 2007, M.C. and her younger sister L.C. were living with their father, his girlfriend and her two children. M.C., L.C., and the girlfriend’s children were placed with a foster family after M.C., then six years-old and the oldest of the children, called 911 stating that she and the other children had been left at home without supervision. The father’s home was found to be in very poor condition, with food and garbage scattered throughout.

The court awarded temporary custody to Children’s Services and stated a goal of reunification. The court ordered that the father take parenting classes, undergo a mental health examination, and keep his home clean and well-maintained.

A year later, M.C. and L.C. returned to their father’s home after the magistrate determined that the father had successfully completed his service plan. A few months later, Children’s Services filed a second motion for a shelter care hearing due to concerns that the father had become intoxicated at a party, his keys were confiscated from him for safety reasons and he became infuriated when he could not obtain his keys to drive home. The police were called and he was tasered. The children witnessed the event. As a result, the court granted custody of the children to Children’s Services.

A new case plan was filed, requiring the father to undergo mental health services, drug and alcohol assessments, and to obtain domestic violence treatment. Although the father completed each requirement of the case plan, Children’s Services filed a motion for permanent custody of M.C. and L.C. because the father was still residing with his girlfriend, whom M.C. stated she feared. The girlfriend previously admitted to physically abusing M.C. on one occurrence. M.C. stated she did not want to live with her father so long as his girlfriend resided there. Further, the caseworker described the father’s and the girlfriend’s relationship as “chaotic and dangerous,” and the caseworker had requested that the father not live with the girlfriend.

The father’s home was still in a state of disrepair with trash, dirty dishes, and dirty laundry scattered around. The children’s mother lived in North Carolina and contacted them sporadically.

The caseworker stated that granting permanent custody to Children’s Services was in the best interests of the children. Further, the caseworker stated that M.C. and L.C. were doing well in the foster home and that the father’s brother, who lives in North Carolina, was a potential adoptive home.

The children’s Guardian Ad Litem testified that the father’s parental rights should be terminated because he had been unable to remedy the problems and because the children needed permanency. The GAL also testified that M.C. stated her living preference as follows: (1) live with her family in North Carolina, (2) live with
her father if his girlfriend did not live there, (3) remain in the foster home.

The GAL advised the court that his recommendations and M.C.’s wishes conflicted. The mother’s attorney then suggested the children be appointed an attorney to represent their wishes. The court determined it was unnecessary, finding that the GAL’s recommendations were not inconsistent with M.C.’s wishes. The court granted Children’s Services motion for permanent custody.

The father appealed. One of father’s arguments was that the court erred by not appointing counsel to the children when the wishes of the children conflicted with the GAL’s recommendations.

The Ohio Court of Appeals held that the lower court did not err in failing to appoint counsel to the children. The court found that the children’s wishes and the GAL’s recommendations did not diverge to the point where an attorney was needed to represent the children’s wishes.

The court stated that each child expressed love for their father and wished to live with him under the condition that his girlfriend did not live there. However, the girlfriend remained in the home and the children feared her. Further, M.C. hoped to live with family in North Carolina. By granting permanent custody to Children’s Services, the opportunity existed for the children to be adopted by family in North Carolina. Kevin was indicted for aggravated assault with a deadly weapon and sentenced to 16 years confinement. Kevin appealed, alleging that the trial court abused its discretion in waiving jurisdiction and transferring his case to adult criminal court.

The Texas Court of Appeals heard Kevin’s appeal, first stating that the standard of review was abuse of discretion, meaning the appellate court would only disturb the juvenile court’s transfer if there was an abuse of discretion.

Under Texas law, “A juvenile court may waive its exclusive jurisdiction and transfer a child to a criminal court if: (1) the child is alleged to have committed a felony; (2) the child was fifteen years of age or older at the time the offense occurred, and the offense allegedly committed is a second or third degree felony, or a state jail felony; (3) no adjudication hearing has been conducted concerning the alleged offense; (4) after a full investigation and hearing the juvenile court determines there is probable cause to believe the child committed the offense alleged, and that because of the seriousness of the offense or the child’s background, the welfare of the community requires criminal prosecution.” TEX. FAM. CODE ANN. § 54.02(a)(1), (2)(B), (3).

Kevin argued that the juvenile court erred when it found that, given the seriousness of
the offense coupled with Kevin background, a transfer to adult criminal court was warranted to ensure the welfare of the community. Secondly, Kevin argued that the lower court erred in holding that the procedures, services and facilities available to the juvenile court were inadequate for his rehabilitation. Kevin argued that he could be adequately rehabilitated and that the community would be protected through the juvenile court’s option for determinate sentencing, which allows the court to commit a youth to custody of the Texas Youth Commission with a possible transfer to the Texas Department of Criminal Justice-Institutional Division. Under the Texas Family Code, the prosecutor may refer petition to grand jury. The grand jury may then certify that the juvenile court has jurisdiction to impose a determinate sentence. If the prosecutor does not refer the petition to the grand jury, then the juvenile court will not have jurisdiction to impose a determinate sentence.

The Texas Court of Appeals focused on the fact that the decision to refer the petition to the grand jury is optional for the state. If the state chooses not to refer such a petition, then the juvenile court has no jurisdiction to order a determinate sentence. In this case, the state chose to request a waiver of jurisdiction and transfer to adult criminal court rather than refer the petition to the grand jury; therefore, the juvenile court was unable to impose determinate sentencing. The court overruled Kevin’s appeal and affirmed the trial court’s waiver and transfer, basing its holding on the fact that the juvenile court did not have proper jurisdiction to order determinate sentencing.

Delinquency / Disposition

SUMMARY BY NACC LEGAL INTERN ELLEN PEPPER, JD CANDIDATE, UNIVERSITY OF COLORADO LAW SCHOOL.

When B.F.L. was 15 years old, he was charged with burglary, criminal mischief, theft and misconduct involving a controlled substance. Because he was a first-time offender, the court held that his delinquency case would be dismissed if he showed rehabilitative progress within six months. In order to show compliance with rehabilitative progress, the court ordered B.F.L. attend school regularly, live with his mother, and not ingest illegal substances.

One month later, B.F.L. stopped attending school and attempted to commit suicide. B.F.L. was placed in the custody of the Fairbanks Youth Facility and was thereafter adjudicated a delinquent due to his failure to achieve rehabilitative progress.

Under the Alaska Statutes 47.12.120(b), the court may elect one of the following three levels of government supervision for delinquents: (1) place the minor on probation and release the minor to the custody of the parents or guardians; (2) give custody of the minor to the Department of Health and Social Services (the Department) with the authority to release the minor to the custody of parents, place the minor in a foster home or “any suitable non-detention residential facility;” or (3) commit the minor to the custody of the Department with the authority to make any appropriate placement. In considering placement, the court is required to impose “the least restrictive alternative” given the rehabilitative needs of the minor coupled with the need to protect the public.

After considering the options, the court placed B.F.L. on probation on the condition that he complete a residential treatment program. After completion of the program, he was to be released to the custody of his sister in Idaho. Shortly after being placed in the residential treatment program, B.F.L. escaped. Once found, the residential program refused to readmit him, stating the program’s supervision was not adequate to cope with B.F.L.’s behavior. B.F.L. was then transferred to the Alaska Military Youth Academy, where he soon absconded.

Because of his repeated problems, the court issued a disposition allowing the Department to place B.F.L. in a detention center. At the detention center, B.F.L. continued to have problems and was verbally abusive to the staff. Despite his behavior, at his review hearing, the court placed B.F.L. on probation and released him to live with his mother. Within weeks, his mother contacted the Department to report that B.F.L. was misbehaving. At his probation revocation hearing, the court once again issued a disposition allowing the Department to place B.F.L. in a detention center, the most restrictive alternative available to the court. The Alaska Court of Appeals reviewed the lower court’s holding.

B.F.L. argued that the lower court erred because his case was not extreme enough to warrant the most restrictive alternative, citing...
**Matter of J.H.**, which held that in children’s proceedings the ultimate goal is rehabilitation; therefore, there is “a strong presumption against institutionalization…in all but extreme cases.” 758 P.2d 1287, 1291.

The state argued that the Delinquency Rule 11(e) and Alaska Statutes 47.12.140 superseded the *J.H.* case. Delinquency Rule 11(e) states that the Department must prove by a preponderance of the evidence that the disposition is the least restrictive alternative available given the juvenile’s rehabilitative needs and the need to protect the community.

The Alaska Court of Appeals found that the lower court did not err in issuing the most restrictive disposition. The court stated that the *J.H.* holding was a common-law holding that occurred before the Alaska Supreme Court enacted Delinquency Rule 11(e) and the legislature enacted AS 47.12.140. The Alaska court rule and statute have replaced any common-law rulings.

The court of appeals held that the Alaska court rule and statute still contain a presumption against involuntary removal of a minor from his home but they do not require that only in the most extreme cases may the court remove the minor from his home. The ultimate goal, established by rule and statute, in Alaska is not only to rehabilitate the juvenile but also to protect the community.

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**NOTICE TO READERS**  Decisions reported in *The Guardian* may not be final. Case history should always be checked before relying on a case. Cases and other material reported are intended for educational purposes and should not be considered legal advice. Cases reported in *The Guardian* are identified by NACC staff and our members. We encourage all readers to submit cases. If you are unable to obtain the full text of a case, please contact the NACC and we will be happy to furnish NACC members with a copy at no charge.

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**The Fifteenth Annual Rocky Mountain Child Advocacy Training Institute 2011**

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Starting in January 2011, the U.S. Children’s Bureau’s National Quality Improvement Center on the Representation of Children in the Child Welfare System (QIC-ChildRep) is providing a waiver for one-half of the $600 Certification Fees. The waiver will be applied to the $300 Application Fee on a first-come first-served basis to the first 200 applications submitted to the NACC. Attorneys who receive the QIC ChildRep Waiver will be responsible for the $300 Examination Fee. To be eligible for the Waiver attorneys must submit with their application a commitment to sit for the exam if eligible.

Contact the NACC to obtain the Certification Standards and an application or visit naccchildlaw.org/?page=Certification for additional information.
Child Welfare Law Specialist
North Carolina Certification Presentation

On November 15th, a special ceremony was held for North Carolina's inaugural group of child welfare law specialists. Certificates were presented by Mecklenburg County Bar president, Nancy Roberson. The local bar is now partnering with North Carolina's newly certified specialists to do a series of trainings.
Child Welfare Attorney Specialty Certification

Child Welfare Attorney Specialization is a program of the National Association of Counsel for Children (NACC) whereby the NACC certifies qualified attorneys as Child Welfare Law Specialists (CWLS). Attorneys receive the CWLS credential from the NACC by showing their proficiency in child welfare law through a comprehensive child welfare law competency process.

For more information on Child Welfare Attorney Specialization, contact the NACC.
Call toll-free: 1-888-828-NACC  
Visit our website: www.NACCchildlaw.org  
Or email: advocate@NACCchildlaw.org
The Voice of Children’s Advocacy

With 60 member organizations and a presence in nearly every state, Voices for America’s Children is the nation’s largest network of multi-issue child advocacy organizations. Our nationwide nonpartisan network leads advocacy efforts at the community, state and federal levels to improve the lives of all children, especially those most vulnerable, and their families.

Big wins happen for kids because of changes in government policy. Voices’ nonpartisan advocacy in Washington, DC and across the nation helps deliver those wins. For more than a quarter-century, Voices for America’s Children has been on the forefront of every major child policy victory. In Washington, DC, state capit- tals and city halls across the country, we speak up for children. From one-on-one policymaker meetings to front page news stories, the Voices nationwide network is putting children on government’s agenda.

We focus on six key policy goals to advance our vision and agenda:

Equity and Diversity: All children achieve their full potential in a society that closes opportunity gaps and recognizes and values diversity. This goal also informs the work of all other core goals.

Health: All children receive affordable, comprehensive, high-quality health care.

School Readiness: All children and their parents receive the services and supports to enable them to start school prepared for success.

School Success: All children have an equal opportunity to attend an adequately and equitably financed public school meeting rigorous academic standards aligned with the needs of the 21st century workforce.

Safety: All children are safe in their homes and communities from all forms of abuse, neglect, exploitation, violence and risky behaviors; and contribute to community well-being.

Economic Stability: All children live in families that can provide for their needs and make investments in their future.

The Voices network was instrumental in persuading key members of Congress to support the health care reform bill and the Children’s Health Insurance Program which provide coverage to millions of children and their families. In fact, Voices was one of only a handful of groups recognized for their efforts by House Speaker Nancy Pelosi shortly before the historic health care reform vote in March 2010.

Senator Orrin Hatch (R-UT) also praises our nationwide network, “I’ve long admired Voices for America’s Children and the sterling work it does advocating for the nation’s most precious resources, our children.”

Voices is a founding member of the Children’s Leadership Council, a coalition of more than 50 leading national policy and advocacy organizations. Learn more at www.childrensleadershipcouncil.com.

Learn more about how the Voices network champions children’s needs at every level of government. Join us at www.Voices.org.
2010 Member Organizations by State

VOICES for Alabama’s Children
Children’s Action Alliance (AZ)
Arkansas Advocates for Children & Families
Children Now (CA)
Children’s Advocacy Institute (CA)
Children’s Partnership (CA)
Coleman Advocates for Children & Youth (CA)
Kids in Common (CA)
Colorado Children’s Campaign
Connecticut Association for Human Services
Connecticut Voices for Children
KIDS COUNT in Delaware
DC Action for Children
Children’s Campaign, Inc. (FL)
Voices for Georgia’s Children
Good Beginnings Alliance (HI)
Idaho Voices for Children
Voices for Illinois Children
Child & Family Policy Center (IA)
Kansas Action for Children
Kentucky Youth Advocates
Agenda for Children (LA)
Maine Children’s Alliance
Advocates for Children & Youth (MD)
Massachusetts Citizens for Children
Michigan’s Children
Priority Children (MI)
Partnership for Children (KS/MO)
Voices for Children in Nebraska
Children’s Advocacy Alliance (NV)
Children’s Alliance of New Hampshire
Association for Children of New Jersey
New Mexico Voices for Children
Citizens’ Committee for Children of New York
Schuyler Center for Analysis & Advocacy (NY)
Westchester Children’s Association (NY)
Action for Children North Carolina
North Dakota KIDS COUNT!
Voices for Ohio’s Children
Oklahoma Institute for Child Advocacy
Children First for Oregon
Pennsylvania Partnerships for Children
Public Citizens for Children & Youth (PA)
Rhode Island KIDS COUNT
Children’s Trust of South Carolina
South Dakota KIDS COUNT
South Dakota Voices for Children
Black Children’s Institute of Tennessee
Tennessee Commission on Children & Youth
CHILDREN AT RISK (TX)
Texans Care for Children
Voices for Children of San Antonio
Voices for Utah Children
Community Foundation of the Virgin Islands
Voices for Virginia’s Children
Voices for Vermont’s Children
Children’s Alliance (WA)
West Virginia KIDS COUNT Fund
Wisconsin Council on Children and Families
Wyoming Children’s Action Alliance
Federal Policy Update

Health Reform Bills/Voluntary Home Visiting Legislation

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Public Law 111-148). The law includes an early childhood, voluntary home visitation grant program through the Maternal and Child Health Bureau in HHS with a capped entitlement funding level of $1.5 billion over 5 years. Home Visiting program implementation efforts by the MCH Bureau are now in progress, with key guidance to states already issued.

The health care reform law obviously also has significant impacts on children's physical and mental health coverage. The complexity of those issues precludes meaningful presentation in this brief update, but the following is an overview of the provisions for children and families that are effective beginning this year, from the Georgetown University Center for Children and Families (CCF):

March 23, 2010 (date of enactment)
- States must at least maintain current Medicaid and CHIP coverage and enrollment procedures.

After September 23, 2010 (as a new health plan year begins)
- Young adults can remain on their parents’ health plan until age 26.

- Children with insurance can no longer be denied coverage for pre-existing conditions.
- Insurance plans can no longer impose lifetime caps or restrictive annual limits on coverage, and can not rescind coverage when a person becomes ill.
- New health plans after September 23, 2010 must provide free preventive care and screenings identified in Bright Futures (the American Academy of Pediatrics’ “gold standard” for preventive care).

Other key provisions that will affect families and children (as also reported by Georgetown’s CCF) include:
- Making coverage more affordable for middle class families by boosting their bargaining power through new health exchanges and providing tax credits to those who need extra help buying insurance.
- Providing Medicaid coverage to low-income families with incomes up to 133% of the federal poverty line, allowing children and parents to be covered together.
- Continuing the Children’s Health Insurance Program (CHIP) which has successfully worked in partnership with Medicaid to drive down the number of uninsured children to its lowest level in over 20 years (CHIP is continued through at least 2019; funding is provided through fiscal year 2015).
- Providing Medicaid coverage for former foster care children; children up to age 26 who “age-out” of foster care will be eligible to continue receiving Medicaid (and EPSDT benefits).

FY 2011 Budget and Appropriations

In early February 2010, President Obama submitted his FY 2011 budget proposal, which included continued funding for most current programs that benefit court-involved children and families, although there were some proposed funding reductions, most notably in the juvenile justice and delinquency prevention area.

Congress has begun action on the FY 2011 appropriations bills that include the programs that most directly affect court-involved children and families, although there were some proposed funding reductions, most notably in the juvenile justice and delinquency prevention area.

For further information on any federal legislation (including copies of bills, copies of committee reports, floor votes, etc.), visit http://thomas.loc.gov/.
million over FY2010 and Head Start funding by $866 million above 2010; the Senate Committee bill increases Child Care funding by $1 billion and Head Start funding by $990 million, and also includes a new $300 million Early Learning Challenge Fund that will provide competitive grants to states to raise the quality of early childhood education programs.

Final funding levels for FY 2011 have not yet been determined.

Child Safety in Boot Camps and other Private Residential Programs

H.R. 911, the Stop Child Abuse in Residential Programs for Teens Act of 2009, was voted out of House Education and Labor Committee on 2/11/09, and was adopted (under suspension of the rules) by the full House of Representatives by a vote of 295-102 on 2/23/09; a similar bill had passed on the floor of the House on 6/25/08, but was never enacted. The legislation sets minimum standards for boot camps and other private residential programs as well as civil penalties for violation of those standards, and provides for federal oversight of such programs, including mandates that complaints of child abuse/neglect in the programs be investigated. No Senate action has been scheduled.

Gangs Legislation

On 1/6/09, Senators Feinstein and Hatch reintroduced the latest version of their “gangs bill” as S. 132. This bill includes mandatory minimums and other enhanced penalties, and increased federalization of gang crime, although the bill now also includes some prevention resources, and no longer has the previously-included section providing for expanded prosecution of juveniles as adults in federal court. Companion legislation in the House, H.R. 1022, was introduced on 2/12/09 by Reps. Schiff and Bono Mack. No House or Senate Judiciary Committee markup of any of these bills has been scheduled.

On 2/13/09, the Chairman of the House Judiciary Subcommittee on Crime, Rep. Bobby Scott, introduced the Youth PROMISE Act, H.R. 1064, along with Rep. Castle and several other cosponsors; the bill now has over 230 House cosponsors. The bill would support a variety of proven-effective prevention and intervention approaches to reduce youth involvement in gangs and violent crime. The Senate companion legislation, S. 435, was introduced on 2/13/09 by Senators Casey and Snowe. No dates for House floor consideration and Senate Committee action have been set.

Juvenile Justice Reauthorization Bills

On 3/24/2009, S. 678, a bill to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act, was introduced by Senators Patrick Leahy, Herb Kohl, and Arlen Specter. The Senate Judiciary Committee marked-up the bill on December 17, 2009, but no Senate floor action has been scheduled, and no House companion bill has been introduced yet. On 3/16/2009, Rep. Bobby Scott (Chairman of the House Judiciary Subcommittee on Crime) introduced a simple reauthorization bill (H.R. 1514) for the Juvenile Accountability Block Grants (JABG) program; on May 19, 2010, H.R. 1514 passed the House (under suspension of the rules) by a vote of 364-45. No Senate action has yet occurred on this legislation.

Child Welfare State Demonstration Authority Legislation

H.R. 6156, legislation to renew through FY2016 the authority of the Secretary of Health and Human Services (HHS) to authorize states to conduct child welfare program demonstration projects to promote the objectives of part B (Child and Family Services) or E (Foster Care and Adoption Assistance) of title IV of the Social Security Act, was introduced by Rep. McDermott (D-WA) on September 16. The bill passed the House by voice vote (under suspension of the rules) on September 23, 2010. No Senate action has yet been scheduled.

International Adoption Simplification Legislation

S. 1376, the International Adoption Simplification Act, amends the Immigration and Nationality Act to include in the definition of “child,” and thus in the exemption from required admissions vaccination documentation, certain children who have been adopted in a foreign country that is a signatory to the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption (Hague Convention) or who are emigrating from such a country for U.S. adoption. The legislation includes in such definition and exemption of a
child who is under the age of 18 at the time an immediate relative status petition is filed on his or her behalf, has been adopted abroad or is coming for U.S. adoption, and is the natural sibling of: (1) an adopted child from a Hague Convention signatory country; (2) a child adopted under the age of 16 who has lived with the adoptive parents for at least two years, or a child who has been abused; or (3) an orphan who was under the age of 16 at the time an immediate relative status petition was filed on his or her behalf. The legislation also makes such provisions effective on the date of enactment of the legislation, except that such an alien sibling who has attained the age of 18 on or after April 1, 2008, shall be deemed to meet the age requirement if a petition for classification of the alien as an immediate relative is filed not later than two years after the date of the enactment of this Act. This bill passed in the Senate on July 21, 2010 by unanimous consent, and then passed in the House on November 15, 2010 by voice vote (under suspension of the rules). The bill was then signed into law by the President on November 30, 2010.

**Reauthorization of the Child Abuse Prevention and Treatment Act**

S. 3817 reauthorizes the Family Violence Prevention and Services Act through FY2015, and reauthorizes through FY2015 the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978 and the Abandoned Infants Assistance Act of 1988; the legislation also makes modest modifications in the reauthorized programs’ grant requirements. This bi-partisan legislation — cosponsored by Senators Dodd (D-CT), Enzi (R-WY) and Harkin (D-IA) — was introduced on September 22, 2010. The Senate Committee on Health, Education, Labor and Pensions completed mark-up of S. 3817 on December 1, 2010. No further action has been scheduled.

**Criminal History Background Checks by Child-Serving Organizations**

H.R. 1469, the Child Protection Improvements Act of 2010, amends the National Child Protection Act of 1993 to direct the Attorney General to: (1) establish policies and procedures for streamlining the process of obtaining nationwide criminal history background checks and for facilitating widespread access to such background checks by public or private child-serving organizations; (2) establish a criminal history review program to provide reliable and accurate information on the criminal history of an individual who has or seeks to have unsupervised access to a child and who is employed by, volunteers with, or seeks to be employed by or volunteer with, a child-serving organization or who owns or operates, or seeks to own or operate, a child-serving organization; (3) conduct an annual assessment of state agencies to determine whether such agencies operate programs to ensure that a wide range of child-serving organizations have affordable and timely access to nationwide criminal history background checks; (4) compile demographic and other data on the implementation of this Act; and (5) submit reports to Congress on the programs and procedures established under this Act and on the data compiled under this Act. This bill passed in the House (under suspension of the rules) by a vote of 413-4 on July 22, 2010. No Senate action has occurred yet on the Senate companion legislation, S. 1598, though action in the Senate Judiciary Committee is tentatively scheduled for December 8, 2010.

**Limitations on Physical Restraint or Seclusion of Students in Schools**

H.R. 4247 restricts elementary and secondary school personnel from managing any student by using any mechanical or chemical restraint, physical restraint or seclusion. This legislation, sponsored by Rep. George Miller (D-CA), was passed by the House on March 3, 2010 by a vote of 262-153, but no action on the legislation has occurred in the Senate.

9th Circuit Upholds Private Remedy for Child Welfare Act in Family Foster Care Rate Case:

In California Foster Parent Association, et al. v. Wagner, the Ninth Circuit held that the instruction for family foster care rates to meet eight enumerated costs under the federal Child Welfare Act (Title IV-E of the Social Security Act) was privately enforceable and was being violated by the State of California —__F.3d__ (9th Cir. 2010). The state had successfully argued in the medicaid case of Sanchez v. Johnson 416 F.3d 1051 (9th Cir. 2005) against any private remedy. There, the statute’s mandate for equal access between patient groups was violated by discriminatory rates at a fraction of MediCare or private insurance levels — discriminating against the disabled (and in the related Fogarty Oklahoma case, against pediatricians serving children). See LATimes article at: http://articles.latimes.com/2010/aug/30/local/la-me-0831-foster-parents-pay-20100830.

A Formula for Foster Care Success


NACC Call for Abstracts

The NACC is soliciting abstracts for presentations at its 34th National Child Welfare, Juvenile, and Family Law Conference, August 30 – September 1, 2011, in San Diego, CA. For more information, please visit: www.NACCchildlaw.org. Submissions must be submitted online, and received by February 1, 2011.

Congratulations to John Stuemky!

Dr. Stuemky, NACC Board Member, is among the first class of pediatricians to become board certified in child abuse. He joined over a hundred colleagues in sitting for the first exam! As most of you know, Dr. Stuemky’s guidance and wisdom from the medical world was influential in developing the NACC’s Child Welfare Attorney Specialization program.

Read more from the Tulsa World article, Doctor Certification to Aid Child Abuse Detection: This Subspecialty Will Help Pediatricians Weed Out False Claims as Well


Assessing the Quality of Child Advocacy in Dependency Proceedings in Pennsylvania:


9th Circuit Upholds Private Remedy for Child Welfare Act in Family Foster Care Rate Case:

In California Foster Parent Association, et al. v. Wagner, the Ninth Circuit held that the instruction for family foster care rates to meet eight enumerated costs under the federal Child Welfare Act (Title IV-E of the Social Security Act) was privately enforceable and was being violated by the State of California —__F.3d__ (9th Cir. 2010). The state had successfully argued in the medicaid case of Sanchez v. Johnson 416 F.3d 1051 (9th Cir. 2005) against any private remedy. There, the statute’s mandate for equal access between patient groups was violated by discriminatory rates at a fraction of MediCare or private insurance levels — discriminating against the disabled (and in the related Fogarty Oklahoma case, against pediatricians serving children). See LATimes article at: http://articles.latimes.com/2010/aug/30/local/la-me-0831-foster-parents-pay-20100830.
**NACC Children’s Law Listserv Information Exchange.**

All NACC members are encouraged to join the NACC Listserv, which provides a question, answer and discussion format on a variety of children's law issues. To join, send an email to: advocate@NACCchildlaw.org, and request to be added.

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**Career Center**

Full Job Descriptions are available at [www.NACCchildlaw.org/networking](http://www.NACCchildlaw.org/networking)

**NACC Law Student Internship Program**

NACC is looking for interns for SUMMER 2011. Unpaid / school credit only. NACC interns are responsible for: Assisting with substantive legal matters in conjunction with the Staff Attorney and President/CEO, including: conducting research and providing referrals for the NACC Resource Center, assisting in the administration of the NACC’s Amicus Curiae program, drafting and editing cases for *The Guardian*, assisting with conference planning, and assisting with administrative tasks as necessary. Applicants should have a minimum of one year of law school completed and a demonstrated interest in child welfare law. Please send resume and cover letter to: Kellogg.Anne@tchden.org.

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**Publications**

*Child Welfare Law and Practice: Representing Children, Parents, and State Agencies in Abuse, Neglect, and Dependency Cases (2nd ed.)*

This important book presents the body of knowledge that defines child welfare law as a unique and specialized field. Over the past several decades, a national model for child welfare practice has emerged, and in 2004 the American Bar Association designated child welfare law as a formal legal specialty. This book will serve the reader as a practice reference, a training manual, and a certification exam study guide.

In this second edition the authors have added ten new chapters and made extensive updates and revisions to the first edition.

**New and Expanded Topics Include:**

- Indian Child Welfare Act
- Investigative interviewing of the child
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- The practice of child welfare casework
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- Representing parents
- Federal due process
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- The transition of youth from foster care to adulthood
- Plus many more!

To learn more and/or order the book, please visit: [www.bradfordpublishing.com](http://www.bradfordpublishing.com).

**Note:** NACC members are entitled to a 20% discount, (enter the code NACC in the shopping cart when you checkout).

**Born for Love: Why Empathy Is Essential — and Endangered**

by Bruce Perry and Maia Szalavitz.

Available at [www.harpercollins.com](http://www.harpercollins.com).


The book guides readers as they navigate the complex child welfare system and plan interventions and treatment. It is written from the perspective of a judge (Judge Cindy S. Lederman, Circuit Judge—11th Judicial Circuit, Miami), a psychologist (Joy D. Osofsky, Ph.D., Professor of Pediatrics and Psychiatry, LSU Health Sciences Center), and an early intervention expert (Lynne Katz, Ed.D., Director, Linda Ray Intervention Center, Miami). Available at: [www.brookespublishing.com](http://www.brookespublishing.com).

**Daycare and Delinquency**

NACC Affiliate News

NACC affiliates assist in fulfilling the NACC mission and provide members the opportunity to become more directly and effectively involved at the local level. If you are interested in participating in local activities through an affiliate, or wish to interact with other professionals in child welfare, juvenile, or family law, please contact the NACC. The NACC will direct you to a local affiliate, or assist you in forming one in your area. Affiliate development materials and a current list of affiliates are available at: www.NACCchildlaw.org/about/affiliates.html.

Georgia Association of Counsel for Children (GACC)

GACC hosted the second annual Georgia Youth Law Conference, October 27–29, in Atlanta. Conference attendees included approximately 300 children’s attorneys, parent attorneys, agency attorneys, guardians ad litem, juvenile defenders and other professionals practicing in Georgia Juvenile Courts. The event proved to be a success, generating great interest from the surrounding community and legal professionals in the state of Georgia.

For more information about the GACC, email: info@gaccchildlaw.org or visit: www.gaccchildlaw.org/.
The National Association of Counsel for Children thanks the following donors and members for their contribution to the NACC, and to children and families.

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