

# The Family Defender

ADVOCATING FOR CHILDREN & FAMILIES TOGETHER



A Child Protection Watchdog Group

Issue 15

Summer 2013

**SPECIAL DOUBLE ISSUE: MEDICALLY-COMPLEX CASES IN THE CHILD WELFARE SYSTEM**

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## In re Yohan K.: Parents of Infant with Rare Medical Conditions Known to Mimic Signs of Abuse Exonerated by the Appellate Court of Illinois After Two-Year-Long Battle

by Melissa Staas

Teresa's heart stopped the moment the question left the doctor's mouth: "Have you or your husband done something to your baby?" The day before, on Monday, June 6, 2011, Teresa and her husband K.S.<sup>1</sup> had brought their newborn son, Yohan, to his pediatrician's office to address symptoms of illness that had intensified over



*E.Z. came to the attention of hospital staff due to injuries his mother couldn't explain. The Center's work exonerated her, after she stood up to undue pressure to implicate someone else. See Janet's story p. 12. Photo by Martin Aspera.*

the preceding weekend. While in the examining room, Yohan began having a seizure. The family quickly was rushed to Children's Memorial Hospital ("CMH," now named the Ann and Robert H. Lurie Children's Hospital of Chicago). Teresa

Ms. Staas is the lead attorney for the family in the appellate case reported here. Ellen Domphe represented the parents in the lengthy juvenile court trial. The family did not appeal but after the Office of Public Guardian appealed the decision returning the children to the parents, the Center cross-appealed the decision by the trial court during the adjudicatory phase of the case. The result was a significant precedential decision that will help to exonerate other family members in cases involving unexplained injuries and disputed medical findings in loving and supportive families. The facts in this article are taken from the Center's appellate brief and, in many instances, from the findings the appellate court made in the course of its ruling.

and K.S. arrived at the hospital hoping for some answers from the medical professionals as to why their baby boy had been exhibiting unusual behavior since his birth. Unknowingly, the parents were instead at the precipice of an excruciating nightmare that would drag on for more than two years, forcing them to live apart from their children for fifteen months before they would finally obtain vindication from the Illinois Appellate Court.

### Idyllic Beginnings

Both K.S. and Teresa grew up in India, each in loving, close-knit families that emphasized values of honesty, integrity, and social justice. In 2004, K.S., who received his bachelor's degree from a highly-respected engineering school in Bangalore, and Teresa, who obtained her degree in computer engineering from Mumbai University, met while both working for a multinational technology consulting company. They quickly discovered many

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<sup>1</sup> The father's first name is the same as the family's surname, so that, to protect the family's confidentiality, the father's initials are used in the article.

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### The Family Defender

*is published twice yearly by  
the Family Defense Center*

*Editor-in-Chief* Diane L. Redleaf  
*Contributors* Skye Allen, Emily Ho, Angela Inzano, Ruth Bell Mejias, Alex Rosney, Melissa Staas  
*Layout* Complete Communications, Inc.

## FAMILY DEFENSE BRIEFS

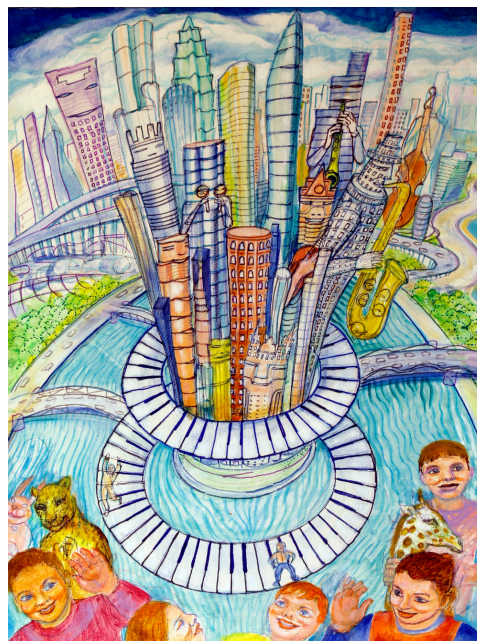
### THE FAMILY DEFENSE CENTERS 5<sup>th</sup> ANNUAL BENEFIT EVENT HONORING FAMILY DEFENDER ANITA WEINBERG

The Center's Fifth Annual Benefit Event will be held on September 22, 2013 at a new venue, the Mid-America Club, from 4 p.m. to 7:30 p.m. The event, chaired by Kathleen Barry & Curtis Warner and Carolyn Shapiro & Joshua Karsh, will honor Anita Weinberg as our 2013 Family Defender. One of the Family Defense Center's founding board members, Anita Weinberg is a clinical law professor in Loyola Law School's ChildLaw Program, where she has directed its innovative Public Policy Clinic since 1998. She is a graduate of Columbia University School of Social Work and Loyola University Chicago School of Law. A gifted policy advocate and teacher, Prof. Weinberg has led countless major child welfare policy initiatives to protect family rights in the child welfare system.



Anita Weinberg  
2013 Family Defender

The 2013 Benefit will also honor individual



Join us on Sept. 22, 4-7:30 p.m. See [www.familydefensecenter.net](http://www.familydefensecenter.net) for tickets.

contributions to the Center's work in 2012-2013 including the lifetime achievements of child development advocate Rhoda Redleaf and nationally-renowned geneticist Dr. Eugene Pergament. This year's Gala will honor the many attorneys who have helped exonerate Julie Q. through the four stages of the appeal process that she had to undertake. The honored Julie Q. team includes: Michael T. Bro (Lead counsel, Jenner & Block), Precious Jacobs, Hon. Michael Otto, Elizabeth Butler, Ajay Athavale, Darren Fish, and LAF Attorneys Richard Cozzola, Steven Pick, and Sara Block (courtesy of Skadden Fellowship). The honored LAF attorneys worked on an amicus brief in the case and had first researched the voidness arguments used successfully by the Julie Q. team. The Gala will also recognize Colleen Garlington of Kirkland & Ellis for her exemplary work in exonerating several parents facing meritless Allegation 60 indicated reports for reasons of an alleged mental disability or domestic violence against them.

The Benefit will feature cocktails, hors d'oeuvres, and a silent and a live auction. This year we will also be raffling an iPad and other prizes. To purchase tickets (including raffle tickets), sponsor the event or donate an auction item, please contact [event@familydefensecenter.net](mailto:event@familydefensecenter.net) or 312-251-9800 x 10.

### Nine Medically Complex Cases All Resolve, At Least in Part, in Families' Favor

In February, 2013, the Center was representing an unprecedented number of medically complex cases in which parents were targeted for alleged child abuse due to a bone fracture or head injury. In two of the cases, both types of injuries were alleged. These complex cases are particularly challenging because the threat of juvenile court intervention is substantial, and the stakes even without such intervention are very high, including restrictive safety plans and the threat of a 20 year child abuse registry. All of the cases originated with treatment for the child at the Ann and Robert Lurie Children's Hospital. On July 1, 2013, the last of the nine cases resolved with an amendment to the indicated findings in favor of the parents. All nine cases have now been resolved without findings of abuse by either of the accused parents. See p. 1 for a detailed discussion of the *In re Yohan K.* case, one of the nine complex cases and one that the Center hopes will serve as an important precedent so that we never again have to defend so many wrongful accusations of child abuse involving medical findings at once.

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# National Reunification Day Gives Families A Chance to Tell Stories, Plant Seeds for Change

The Family Defense Center celebrated National Reunification Month this year on June 15, 2013 at Holy Trinity High School in Chicago. The Center's Third Annual National Reunification Day event's theme was "Our Stories, Tools for Change" and featured a keynote address by Judge Joan Kubalanza about her perspective on the legal processes involved in family reunification in juvenile court case. The program also featured a parent panel in which former Center clients who achieved reunification with their children described their experi-

ences. This program was moderated by Toni Hoy, who had worked with the panelists in writing their stories. (Two of the three parent panelists' stories are printed here, at pp. 17-20). Meanwhile, children who attended the event enjoyed storytelling from Mama Edie Armstrong from the Chicago Association of Black Storytellers and other fun activities. Event-goers participated in workshops on a



variety of topics, from legal advice on safety plans to Theraplay, a way of playing with children that is also healing for them. At the end of the event, parents and children came together to celebrate their success in reclaiming their families and to honor the struggle of those still striving to get their kids back and watched a dance performance by Peruvian dance company Peru Profundo. It was a fun, informative celebration. Plans are already underway for next year's Family Reunification Day, tentatively planned for the afternoon of June 7, 2014.



*Theraplay Psychologist Phyllis Rubin at National Reunification Day playing with E.Z. and his mom, Janet V. See Janet V.'s story at p. 17.*



# JULIE Q. SCORES HUGE WIN FOR ILLINOIS FAMILIES

## *Illinois Supreme Court Affirms that DCFS “Environment Injurious” Label for Families is “Void”*

By Diane L. Redleaf

Julie Q. knew she needed legal help. Her ex-husband had called the DCFS Hotline, in an effort to take custody from Julie. She found that help through the Family Defense Center, which undertook legal representation spanning four years and four levels of the Illinois administrative and court system, all the way to a resounding victory in the Illinois Supreme Court.

Julie's ex-husband called the DCFS Hotline the day after her 9-year-old daughter M.Q. had been with Julie (January 29, 2009). He claimed to DCFS that Julie had locked M.Q. in her room and also said Julie had been drinking. Neither claim was true: the daughter's



Julie Q. and her daughter M.Q.

room had no locks and Julie's AA sponsor attested to her current sobriety. But under the very vague DCFS standards defining neglect as including any “environment injurious,” Julie's acknowledged history of alcoholism, coupled with hotly disputed evidence about her sobriety in July 2008 (months before the Hotline call), became the basis for DCFS' decision to indicate Julie as a child neglecter under the amorphous “environment injurious” ground. Julie's daughter was never harmed and had no signs of any abuse or neglect by either of her parents. The indicated finding was put into the Illinois State Central Register, which operates as a legal blacklist for employment with children and can be used against parents in custody, adoption and juvenile court cases; indicated reports commonly prevent individuals from working with children or even volunteering in their children's schools.

Julie filed a request for an administrative hearing and then a request for administrative review by the Circuit Court, both of which went against her. But she persevered, and appellate courts looked more closely at her legal arguments.

On March 21, 2013, a unanimous Illinois Supreme Court (with Justice Anne Burke not participating in the decision) ruled in our client Julie Q.'s favor that DCFS lacked legislative authority to indicate her as guilty of child neglect. A large team of attorneys, put together by the Center and led by Michael Brody of Jenner & Block as the case reached the appellate court and the Supreme Court, helped to exonerate Julie Q. and thousands of parents who are now benefiting from the final ruling of the Illinois courts. The Illinois Supreme Court's decision affirmed the December 2011 decision of the Illinois Appellate Court, Second District, which had held DCFS did not have legislative authority to enact the policy under which Julie had been indicated. The Appellate Court had also ruled in Julie's favor on her arguments that evidence had been improperly admitted at her administrative expungement hearing (see p. 16 regarding hearsay evidence issues presented in Julie Q.'s appellate case). Julie's name now being cleared and expunged from the Register. Along with Julie Q.'s name, the names of *thousands* of other parents and caregivers who have been wrongly labeled child neglectors are also being expunged from the Register in the wake of the Illinois Supreme Court's decision.

Writing for the Illinois Supreme Court, Justice Rita Garman first noted that the Illinois Abused and Neglected Child Reporting Act (ANCRA), contained a four-part definition of child neglect that had explicitly once included “an environment injurious to the child's welfare,” but that this language had been deleted in 1980. Despite this deletion, in 2001, DCFS promulgated a rule defining allegations of neglect to include what is known as “Allegation 60”, which is “Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare.” Through Allegation 60, DCFS enacted a definition of “environment injurious” to include “situations that place a child at substantial risk of harm due to the effects of being subjected to participating in or witnesses of the physical force or restraint or another,” as one example of an incident that would qualify as placing a child in an environment injurious that could cause a parent to be registered as a child neglecter.

The Illinois Supreme Court concluded that the DCFS rule defining Allegation 60 was void because Allegation 60 itself exceeds DCFS's authority. The Court rejected the argument that DCFS maintained the authority to add to the legislative definition of neglect because the statutory definition includes children who lack “other care necessary for his or her well-being,” because of the clear legislative intent to change the law. The legislative history showing the reasons the “environment injurious” language had been removed demonstrated concern that the term “environment injurious” is overbroad. Moreover, DCFS had earlier been a proponent of the elimination of the language from the statute. The Illinois Supreme Court rejected the suggestion that Allegation 60 addressed the overbreadth issue by

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# Julie Q.

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providing examples and factors for consideration, because the Illinois General Assembly had not given DCFS the authority to create a definition of neglect on its own.

In fact, while Allegation 60, DCFS now *does* possess the authority to draft and implement a new rule that defines an “environment injurious.” But DCFS has not been given a blank check to use the same Allegation 60 policy that the Illinois Supreme Court unanimously said is “void ab initio.” After DCFS tried to reinstate the “environment injurious” language back into Illinois law without any limits on its overbreadth, the Center succeeded in negotiating a much clearer and less broad definition of “environment injurious.” On July 13, 2012, this new statutory definition was signed into law (P.A. 97-0803). The P.A. 97-0803 definition requires that the environment creates a “likelihood of harm to the child’s health, physical well-being, or welfare, and (ii) the likely harm to the child is the result of a blatant disregard of parent or caregiver responsibilities.” “Blatant disregard” is further defined to mean an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm.

Even after it became crystal clear that the Illinois Supreme Court considered Allegation 60 void, DCFS delayed for months in implementing the Court’s decision. It tried to stall removal of parents’ names from the Register as long as it could. The Illinois Supreme Court denied a request for reconsideration of its March 21, 2013 opinion on May 28, 2013. Even after that decision, some DCFS attorneys continued to argue that DCFS had no immediate duty to remove names from the Register because the Supreme Court’s “mandate” (a technical order issuing the relief to the courts below only as to Julie Q. herself) had not yet issued.

While DCFS had been stalling for some time and trying to come up with excuses for not implementing the Illinois Appellate Court’s and Illinois Supreme Court’s decisions, its attorneys have started to argue that DCFS has the authority to keep using Allegation 60 in its void form, without writing new rules conforming to Illinois law as adopted in P.A. 97-0803. To the Center’s knowledge at the time this article is going to print, DCFS has not submitted any rules to the Joint Committee on Administrative Rules that would bring Allegation 60 into conformity with P.A. 97-0803.

One Center client who has been the victim of DCFS’s refusal to amend its void policy is Evie, a doting mother who had been in an abusive relationship with her one-year-old son’s father, but ended that relationship and got a one year order of protection against him in October of 2012. Three months later, DCFS started investigating claims that she was allowing contact between herself and the father, even though there was no claim of any injury to Brandon. Despite showing DCFS her order of protection and despite there being no evidence at all of contact between Evie and Brandon’s father, or Brandon’s presence during the alleged contact, DCFS proceeded as if Evie were a guilty and neglectful parent. After she appealed her case, DCFS attorneys agreed to voluntarily expunge the finding against her, realizing that DCFS could not sustain its burden of proof of neglect. But through the entire course of the investigation and her appeal, DCFS completely ignored the law that clearly does not allow DCFS to label a mother neglectful based on her own status



*Precious Jacobs, Michael T. Brody, and Melissa L. Staas on the steps of the Illinois Supreme Court.*

as a past victim alone. Plainly, Evie’s actions did not meet the statutory definition set forth in P.A. 97-0803.

Center staff members have been contacted by dozens of parents since July 13, 2012 who, like Evie, have continued to be investigated for Allegation 60.

Fortunately, DCFS has now started to expunge Allegation 60 cases if those cases arose prior to July 13, 2012. It is not clear to the Family Defense Center how many indicated findings have been vacated in the wake of the Illinois Supreme Court’s decision, but the Center is seeking that information through a Freedom of Information request. Many parents are, however, getting notices from DCFS’s State Central Register, stating that their Allegation 60 findings have been expunged. DCFS has told the Illinois Supreme Court that there are 13,000 indicated findings for environment injurious issued each year.

The Center has pressed DCFS to expunge all Allegation 60 cases unless and until it adopts a new rule that conforms to P.A. 97-0803. The Center has also asked DCFS to stop accepting Hotline calls or conducting investigations under this Allegation until it adopts new rules meeting P.A. 97-0803’s definition of “environment injurious.” Unfortunately, DCFS has repeatedly refused to discuss its current policies with Center staff. The Center, with the help of Jenner and Block as the lead pro bono counsel in this case, is continuing to press DCFS to prevent future misplaced investigations like the one that took Julie Q. over four years and four levels of court review to resolve, and that have caused grievous harm to tens of thousands of parents and caregivers in Illinois.

Stay tuned to see if further litigation or legislative advocacy will be necessary to finally end the rampant mislabeling of parents as responsible for child neglect under the void DCFS rule that Julie Q. so successfully challenged, with the Center’s and its pro bono partners’ help.

# FAMILY DEFENSE CENTER PAPER TO ADDRESS MEDICAL ETHICAL ISSUES IN CHILD ABUSE PEDIATRICS

By Diane L. Redleaf

The Family Defense Center's work on behalf of wrongly-accused families includes many cases involving physical findings (typically bone fractures and/or bleeding on the brain) that are initially believed to be suspicious of child abuse. A Hotline call has been made to the Illinois Department of Children and Family Services ("DCFS") before the Center's staff are contacted to assist the family. In most of these Center cases, the medical findings that had led to the Hotline call eventually are seen as either accidentally or medically caused. In some of the cases, the findings that caused the child protection investigation are deemed not to have been present at all. While there may have been good reason to consider the possibility that the child was abused in these cases, eventually, the abuse explanation is rejected. In the typical Family Defense Center medically-complex case, the parents are eventually exonerated and the children are returned home if they had been removed following the Hotline call. Months after the Hotline call, the child protection system closes the case and the child protection intervention is finally over.

Does this typical course of action in Center cases show that the child protection and medical assessment system works when child abuse has been alleged based on a medical finding? Or is the system for child abuse investigation, with extensive involvement by medical professionals every step of the way, failing the children and families

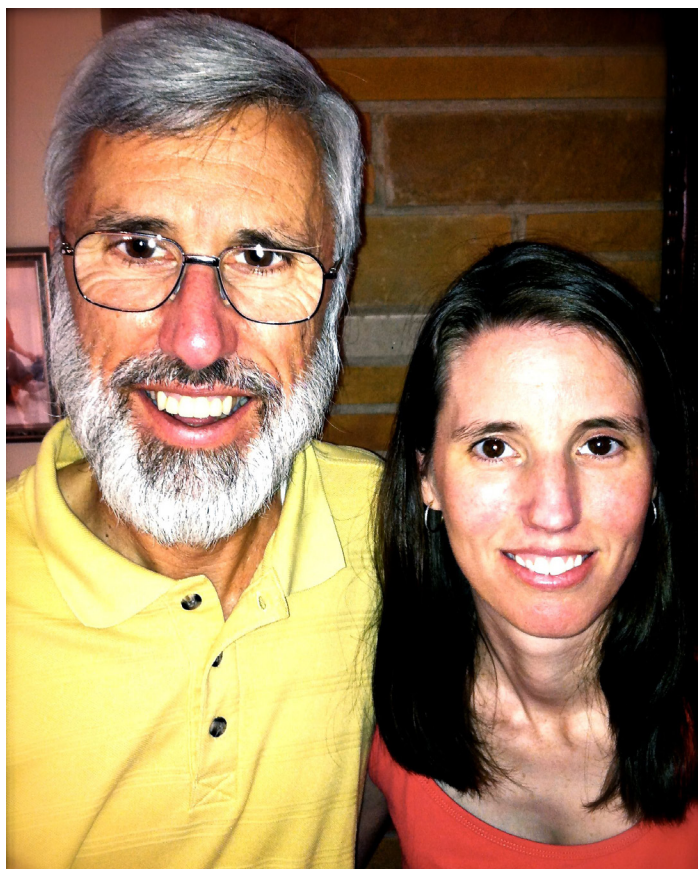
who are the subjects of Hotline calls?

At the Center, we contend that the system of child abuse investigation and medical assessment largely is *failing* the children and families. Moreover, we have come to believe that these failings are due, at least in part, to some medical practices that are ethically questionable at best, and plainly unethical at worst. We have been particularly troubled by the following scenario, which we have observed frequently in the course of representing clients in medically-complex cases. Specifically, a child abuse pediatrician: (1) directs that a Hotline call should be made to DCFS; (2) is herself assigned a few days later to evaluate and report to State DCFS investigators and the courts on a Hotline call that she or her own staff member had made; (3) works under a State contract with DCFS to evaluate the child patient whose parents sought treatment from her own institution; (4) interviews the parent without first disclosing her own DCFS contractual relationship to the parents; (5) issues a final report to DCFS stating her conclusion that the child in question has been the victim of child abuse, without consulting with specialists in other fields of medicine who were involved in the treatment of the patient and who can and do disagree with the child abuse conclusion; and (6) takes no action to mitigate the harm to the family that his or her abuse opinion has caused to the child and parent even when the parent is exonerated of the charge she leveled against the parent as responsible for child abuse.

Doctors are expected to adhere to the Hippocratic principle that they are first to "do no harm." The harm of unethical medical practices can be deep and irreparable. While the child may quickly recover from a toddler fracture, nursemaid's elbow or subdural hematoma that is called in to child protection authorities as suspicious, the trauma families have experienced at the hands of the child protection system does not fade quickly or ever entirely disappear. Moreover, the Center is able to represent only a tiny fraction of the wrongly accused family members in medically complex cases. Legal assistance to families under investigation by medical doctors on contract with DCFS is not available to the vast majority of family members who encounter the child protection/medical system in these cases.

Beginning in November 2011, however, an opportunity arose to tackle the medical ethics issues that occur when parents are wrongly accused of child abuse. Rather than limiting our work to investigating *legal* claims for violation of laws protecting parents and children, we decided to undertake a closer examination of the *ethical* rules that govern physicians' conduct when they are the primary proponents and investigators of the medical merits of child abuse allegations. In undertaking this project, we understood that if we found that physicians' conduct was contrary to their own ethical standards, the Center and other advocates for families might gain a powerful new advocacy tool. In this project, instead of asking "Is the physician's action lawful?" we ask, "Is the handling of child abuse cases by medical professionals consistent with medical ethics requirements?"

The Center's forthcoming analysis of medical ethics issues in child abuse investigations took shape shortly after George Barry, a retired tax attorney, began volunteering with the Center in November 2011.



George Barry, lead author of FDC medical ethics paper, with his daughter Kathleen, Co-Chair of the FDC 2013 Gala.

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# Medical Ethical Issues

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After reading a Center complaint that described how Center clients came to be accused by a child abuse pediatrics fellow in a case in which they eventually were exonerated, George asked me the simple question, “Can a doctor *do* that?” I replied that I thought the doctor’s conduct was troubling from both legal and ethical perspectives, but that research into the medical ethical rules covering physicians was a project we had not been able to undertake due to insufficient staff resources as a result of our many pending projects and cases.

As a person who is deeply interested in ethical requirements governing professionals (with a professional background in the application of ethical issues applied to lawyers, accountants and other financial professionals), George Barry immediately was intrigued by the prospect of using his legal analytical skills to tackle the available medical ethics literature related to physical child abuse evaluations. He also began to research the policies and goals behind the formation of the subspecialty of child abuse pediatrics in 2009 and the effect of that new subspecialty on other doctors’ involvement in alleged child abuse cases.

George Barry’s simple question, “Can doctors ethically *do* that?” has now mushroomed into a year and a half long study of medical ethics as applied to the child abuse pediatric profession and its impact on the practices of doctors generally whenever child abuse has been alleged. Surprisingly little literature has appeared in medical publications regarding the ethical questions raised by the practice of child abuse pediatrics.



The project George Barry began in November 2011 aims to remedy the lack of attention that has been paid to whether the child abuse pediatric field is meeting medical ethics requirements. The project has resulted in a 150-page paper that the Center expects to finalize by September. In the meantime, medical ethics opinions that Mr. Barry has analyzed have been used in several cases involving Center clients.

For example, in one recent Center case, parents were exonerated from child abuse allegations after the Center documented that the same doctor who made the Hotline call had already given DCFS a strongly-worded opinion against the parents on the very same day DCFS assigned her to conduct an “objective” child abuse assessment under its Multi-disciplinary Pediatric Education and Evaluation Consortium (“MPEEC”) contract.

In this report, the Center examines the following issues: “What role did doctors play in the allegation being made in the first place? Are family members’ interests in receiving information and making choices in the best interests of their children compromised by the processes currently in place? And if doctors’ medical ethical duties were compromised, what policies and practices should be adopted so that the

medical care system’s involvement in child abuse cases truly does no harm to the children who are the intended beneficiaries of the concern that brings them into contact with the child protection system?”

This Paper presents five illustrative cases to document in detail how the medical profession interacted with the child protection system to impair the family life of children who were ultimately determined not to be victims of child abuse after all. These cases all arise in Illinois and are representative cases drawn from the Center’s much larger experience in medically-involved child abuse cases.

The Paper reaches several important conclusions that, the Center contends, should gain medical, legal and child protection policy makers’ attention, along with the attention of practitioners in these fields. To summarize these conclusions:

1. The duty of physicians not to become law enforcement officers or to engage in interrogations is compromised by practices under which children are detained at hospitals while medical staff (child abuse pediatricians or social workers under their direction) interrogate parents using police-type tactics that have no place in a medical treatment context.
2. The medical ethics rules recognize that the parent has a unique role in establishing the patient-physician relationship between the child and a particular doctor and in deciding whether to give informed consent for various treatment options that the doctor might recommend. This parental role is not diminished by the fact that a Hotline call was made. However, parents’ decision-making as to their children’s medical care and their access to their child may be compromised by erroneous assumptions about parental responsibility for suspected child abuse.
3. The development of the child abuse pediatric subspecialty, which was recognized by the American Board of Pediatrics in 2009, has led to the child abuse pediatrician becoming the lead voice with child protection agencies in their determination of whether child abuse occurred and whether parental access to children should be restricted. The idea that child abuse pediatricians have superior expertise over that of other doctors with different specialties has been more broadly accepted than is justified, especially if the child abuse pediatrician fails to fully consult with subspecialists in forming his or her abuse conclusions.
4. As a result of development of the child abuse pediatric subspecialty, treating physicians and other doctors increasingly are pressed to give deference to opinions of the child abuse pediatrician, and they appear to be succumbing to that pressure in large numbers. This deference leads to economic and other benefits for treating doctors, but reduces the reliance on physicians who have potentially important information that supports the child and family relationship. Deference, to the exclusion of other opinions, harms the interests of children and families and reduces the quality of information considered by the child protection system in reaching a fair determination of whether child abuse has occurred.
5. The doctor’s ethical obligations to respect patients’ rights of privacy and confidentiality of medical information are not abrogated by the fact that a Hotline call has been made, though current practices appear to assume that those ethical obligations do not exist in this context. Doctors and hospitals routinely share a child’s confidential medical information with state and local authorities and with forensic medical evaluators without paren-

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# Medical Ethical Issues

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tal consent. This overbroad sharing of information beyond the Hotline call itself is a potentially serious breach of medical ethics.

6. Doctors have an ethical duty to protect the child's family relationships and to respect the decisions of parents as to their children's best interests. If child abuse pediatricians work on contracts with state child protection agencies to give opinions against families treated at their own hospitals or when they stop acting as independent and objective evaluators of medical information and instead become advocates in state child protection cases restricting contact between parents and their children, they may be acting contrary to medical ethical principles recognizing the importance of "family-centered care" to children.
7. Physicians and hospitals that have contracts with child protection agencies have a duty to notify parents of children who are being evaluated for child abuse as to these third-party contractual relationships. However, parents are often not informed of the role of the child abuse pediatrician, or given the opportunity to make an informed choice whether or not to participate in the child abuse pediatrician's assessment of the Hotline call, or whether or not to allow access to records for that purpose. This is a violation of medical ethics requirements.
8. Physicians have ethical duties to be honest, objective, independent and guided by current scientific thought in formulating medical opinions and testimony. This duty encompasses five interrelated areas: recognition of the limits of the physician's expertise; a need to consult with other specialists; recognition of the difference between advocacy in the public health role and what is appropriate in formulating an opinion about an individual patient; a duty to be objective and independent; and a duty to limit the caseload to the number of matters that can be handled competently, accurately, thoroughly and expeditiously. The importance of other medical disciplines such as orthopedics

to the accurate determination of child abuse is discussed at some length. If child abuse pediatricians stray from their duties to be objective and set themselves up as the superior doctors whose opinions are the only ones the child protection system needs to consider, they violate this central precept of medical ethics.

9. Physicians also have an ethical responsibility to mitigate damage to families. Yet, in no case handled by the Center has this responsibility been met by the medical community. Although exonerated after fuller investigation or legal proceedings, no Center-represented family has ever received any offer of assistance or healing by any of the physicians who has caused them injury. This is a result of the medical profession's failure to acknowledge the harm that wrongful child abuse allegations cause to children and families and to take meaningful steps to remedy that harm. Reconsidering policies and practices that cause the harm to occur would be an important first step in mitigating this damage.

The Center's Paper is intended to initiate a discussion with the medical profession, medical institutions, child abuse agencies, and the public about the ethical issues raised in the medical assessment of cases of suspected child abuse. To that end, identifying the problems and analyzing the ethical duties, and the potential violations of those duties that we have observed, and proposing some possible remedies is a first step toward creating a more just child welfare system. We hope that readers of this Paper will help the children and families and professionals who have contributed to this Paper to achieve this goal.

Some recommendations in the Paper may be controversial. For example, the recommendation that parents need to be notified when hospitals have third-party contracts with DCFS to conduct child abuse assessments met immediate resistance when Ms. Redleaf made that same suggestion to child abuse doctors who were on a panel in 2011. At the same time, the Paper backs up its recommendations, such as this one, with medical ethics opinions that are not controversial in other areas of medicine. Dialogue about the medical profession's ethical standards in cases when child abuse has been alleged appears to be overdue, because no area of medicine is exempt from the medical ethics principles the Paper discusses.

## Excerpt from the Center's Paper

The child abuse pediatrics literature tends to break down the expertise of the child abuse pediatrician into four areas of knowledge and professional judgment. These are:

- a. expertise in the sociological and demographic aspects and data of child abuse,
- b. expertise in the available data regarding correlation between particular types of injury and child abuse,
- c. expertise in judging the plausibility of a parent's explanation of an injured child's condition, and
- d. expertise in functioning as the liaison to the civil authorities and legal system.

None of these four areas would amount to a claim of such deep expertise in a medical specialty area as to obviate the need in particular cases for specialists in that area, such as orthopedic surgeons, neurosurgeons, and radiologists. Because child abuse cuts across so many areas of medicine and also requires the agency and court liaison function to be fulfilled, it seems doubtful that

any child abuse pediatrician could be truly "expert" in every area of medicine involved in child abuse cases.

Child abuse pediatricians are expected to be knowledgeable in all four areas listed above. The American Board of Pediatrics' content outline for the certification examination in child abuse pediatrics is consistent with these subject areas as the foci of the training these physicians receive. In addition, that content outline also recognizes the continued role of specialists such as neurosurgeons, radiologists, and orthopedists in the evaluation of cases of possible child abuse. While nothing in the content outline suggests that specialists' roles in child abuse investigations are pre-empted by the child abuse pediatrician, current practice is that child abuse pediatricians and their staff routinely advise investigators for DCFS in Illinois that they are the *sole* doctors to whom the investigators should listen and whose opinions have the most weight. This practice occurs even in the face of administrative rules and regulations that call for a more balanced consideration by child protection investigators of all of the specialized medical opinion.



# Release of Information: Consent or Coercion?

By Ruth Bell Mejias, MSW, LCSW<sup>1</sup>



Ruth Bell Mejias

If confidentiality is the cornerstone of social services, informed consent is its mortar. Informed consent has been defined as giving of information in order to gain a client's voluntary agreement to a proposed professional-client interaction (Burkemper 2004). Informed consent must be *voluntarily* given, free from coercion (Alkhatib, Regan, and Jackson, 2008; Regehr and Antle, 1997). Any DCFS investigation as to suspected child abuse or neglect is not voluntary for the persons who are targeted; parents or caretakers do not *choose* to be investigated. Following a Hotline call aimed at protecting a child, the State is authorized to investigate family members without their consent or permission. The act of making a report of suspected child abuse is one of the few exceptions to professional confidentiality; therapists, doctors, even clergy are all mandated reporters.

The involuntary nature of a child abuse and neglect investigation is a major obstacle to obtaining informed consent. While an investigator or worker may not need consent to speak to the alleged victim, family members, or school staff, under some circumstances, they are required to have a signed consent for release of information to speak with other professionals. In order to give an informed consent the parent or caregiver should understand the information requested, the risks and benefits of that consent, and how to retract the consent in a non-coercive environment. The setting in which parents or caregivers interact with DCFS investigators makes this particularly challenging.

When first contacting parents or caregivers, the investigator or worker informs them that DCFS may take custody of their children. They do not usually explain the guidelines used to decide to take that extreme step or the process of taking custody. After hearing this frightening news, parents or caregivers are next often asked to sign "voluntary" consents so that the investigator may contact the children's doctor, the parent's psychiatrist, or a family therapist. The parent is usually not in a clear headed state of mind when these requests are made of them. The investigators generally do not explain the risks and benefits of the release, however. They do not explain that caregivers have a right to refuse or retract consent. They do not explain what the limits of the release are, all of which are important components to consent (Manning and Gaul, 2008). Parents are pressured to give up their rights to confidentiality of medical information, mental health information, substance abuse information and other sensitive information. Indeed, in light of the threat of losing their children, most parents sign any and all documents the worker places in front of them, even ones that waive their fundamental rights to live with their children.

Typically, little time is spent explaining to the parent what the investigator's role is, expectations for the investigation, a time-line of

how long the investigation will take, or what the parents' rights are during the investigation. DCFS's written instructions for completing the Consent for Release of Information provide a list of possible consequences that can be imposed by the worker if the parent does not consent. Each of these scenarios would provide a coercive environment for a parent or caregiver. Some examples include:

"Worker may attempt to screen case into court;"

"Worker may recommend to the court that the child be removed;"

"Visitation may be denied or delayed;"

"The Department may weigh failure to consent in determining whether the parent is compliant with services or has completed tasks satisfactorily." (DCFS Form CFS 600-3, 2005)

Parents generally do not ask questions or seek clarification about the requested consent forms when they are first told that there is a pending Hotline investigation against them. Parents who do question the need for the worker to investigate their lives or to speak to their doctors can be seen as non-cooperative, which can be used against them in the decision to indicate or unfound. Attempts to retract a release can prompt threats as well. Certainly, any sign that the parent is less than fully cooperative can be, and is, used against the parent in the course of the investigation, making it especially challenging for parents to assert their confidentiality rights after having first given DCFS a written consent.

Since the agreement that the investigator procures during an investigation is coerced, DCFS should alter their language and their forms to reflect a more accurate description of the permission granted. A broad statement that "DCFS will take your kids" is not sufficient information for a parent to make an informed choice about their options and it highly coercive to boot. During an investigation, the worker should clearly explain their role, the investigative process, the role of the consent, and the risks and benefits of agreeing and disagreeing to consent. Parents and caregivers are entitled to understand the suspected child abuse or neglect investigation, and to make conscious decisions regarding their families and what information they will share about their private lives.

One benefit of having legal counsel in the investigation process is that counsel can help the client to navigate the consent process, both explaining the consequences of giving and withholding consent and negotiating over the scope of information to be provided, removing from the client the brunt of any accusation of failing to be cooperative with an investigation. Ultimately, both better information to clients, and access to legal counsel to help with the decisionmaking around giving consent, are essential protections for clients who find themselves target of a Hotline call.

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<sup>1</sup> Ruth Bell Mejias is the Intake Coordinator at the Family Defense Center.

# The Family Defense Center and the Innocence Movement: A Natural Collaboration

By Angela Inzano<sup>1</sup>

In 1992, a groundbreaking non-profit legal advocacy organization called The Innocence Project was founded by Barry C. Scheck and Peter J. Neufeld.<sup>2</sup> Since then, and especially in recent years, a growing and ever expanding innocence movement has emerged. The innocence movement includes national and international legal advocacy organizations all committed to identifying, freeing, and supporting innocent individuals who have been wrongfully incarcerated.<sup>3</sup> Many of these organizations are connected through the Innocence Network, which seeks to support and connect these like-minded organizations.<sup>4</sup>

While the Family Defense Center (FDC) does not engage in criminal representation generally, nor does it offer post-conviction services specifically, there are several ways in which our mission, focus, and services overlap with that of the innocence movement. At the outset, as a non-profit organization that provides most of our legal services free of charge, we serve similar populations to those of these innocence projects. In addition, the FDC takes only cases in which its staff believe, after a careful review, that a parent or caregiver has been wrongfully accused of child abuse or neglect. In this way, we work at the front end of the legal system towards the same goal, exoneration of our client, which many innocence projects find themselves working towards at the back end of the legal system. The similarities in our goals have led to a recent natural collaboration between our organization and the Innocence Network.

The most extensive way in which the FDC has recently fostered a re-



(From left to right) FDC Staff Attorney Angela Inzano, Innocence Project founder Barry Scheck, and exoneree Antoine Day, founder of Life After Justice, at the 2013 Innocence Conference.

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1 Angela is a staff attorney at FDC and a former Adjunct Professor for Loyola's Life After Innocence Clinic.

2 Innocence Project, *About the Innocence Project*, <http://www.innocenceproject.org/about/>.

3 At the Innocence Network, *Members*, <http://www.innocencenetwork.org/members>.

4 See At the Innocence Network, <http://www.innocencenetwork.org/>.

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## Release of Information

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lationship with the Innocence Network is through our shared work on medically complex cases, more specifically, cases in which Shaken Baby Syndrome (SBS) has been alleged. In late 2012, the Innocence Network hired a Shaken Baby Syndrome Litigation Fellow, Katherine Judson, whose position was created to support those attorneys working on SBS related cases.<sup>5</sup> The Network also developed a listserv which allows those working on SBS exonerations, including attorneys and medical professionals, to collaborate and network. Our office has worked both with Ms. Judson specifically, and the SBS subsection of the Innocence Network generally, on (1) brainstorming and implementing ideas for general policy reform; and (2) specific cases such as the *In re Yohan K.* case discussed at length elsewhere in this Newsletter (lead article p.1)

In addition, in late 2012 the Center on Wrongful Convictions at Northwestern School of Law launched the Women's Project, a first of its kind organization devoted solely to wrongfully convicted women.<sup>6</sup> Collaboration with the FDC's Mother's Defense Project seems a natural fit given the geographic location of the Women's Project and our desire to launch the Mother's Defense Project on a national scale, as well as the Women's Project's similar mission and understanding of the unique gender-biased ways in which the legal system negatively impacts women. We hope to continue to work towards a collaborative effort in this regard given our successful efforts in collaborating with the Innocence Network on medically complex cases recently.

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5 See Innocence Project, *Staff Directory*, Katherine Judson, [http://www.innocenceproject.org/Content/Katherine\\_Judson.php](http://www.innocenceproject.org/Content/Katherine_Judson.php).

6 Bluhm Legal Clinic Center on Wrongful Convictions, *Women's Project, About the Project*, <http://www.law.northwestern.edu/legalclinic/wrongfulconvictions/womensproject/about/>.



# HON. NANCY C. DREHER FUND SUPPORTS MEDICALLY-COMPLEX CASE ADVOCACY AND RESEARCH

The Hon. Nancy C. Dreher Medical-Legal Accountability Fund has been established in memory of our friend and supporter Hon. Judge Nancy C. Dreher, wife of Roger and mother of Laura Dreher Timmel. The Dreher and Timmel families have become staunch advocates for justice for families encountering medically unsupported allegations that cause grave harm to their family life. As the Chief Judge for the Bankruptcy Court for the District of Minnesota, Judge Dreher was highly regarded for her intellect and for holding parties and litigants to high ethical standards and professionalism—standards she sought to apply in the child welfare system in America through her support of the Family Defense Center’s advocacy for families.



*The late Hon. Nancy C. Dreher.*

The fund, has been initiated through a generous memorial gift by Roger Dreher in honor of his wife, who died on November 23, 2012. With support from donors in Minnesota at a fundraiser on

April 18, 2012, the fund has already raised \$17,400 to support the many of the activities of the Family Defense Center, including this special issue newsletter. The specific fund purposes are:

1. Research, writing and advocacy adherence to medical ethics standards in cases involving child protection allegations.
2. Representation of persons whose incomes fall below 250% of poverty who have medically complex cases and a meritorious claim of innocence as to the cause of their children’s injuries.
3. Representation of parents and children with physical and mental disabilities whose need for reasonable accommodation are not met by the child protection system.



*Laura Timmel, daughter of Hon. Nancy Dreher, with her children.*

4. Payment of medical expert fees as necessary to adequately represent low income clients.
5. Training lawyers and other professionals in the handling of defense of medically complex child protection cases.

The Fund will also be the focus of the Center’s “fund a need” appeal at our upcoming Gala on September 22, 2013. Please consider a donation to help us continue our work on behalf of wrongly accused family members in medically complex cases.

## The Hon. Nancy C. Dreher Medical-Legal Accountability Fund

Initiated through a generous memorial gift by Roger Dreher in honor of his wife who died on November 23, 2012, the fund will be used to support the following activities of the Family Defense Center:

1. **Research and advocate** for adherence to medical ethics standards in cases involving child protection allegations.
2. **Represent persons whose incomes fall below 250% of poverty** who have medically complex cases and a meritorious claim of innocence as to the cause of their children’s injuries.
3. **Represent parents and children with physical and mental disabilities** whose needs for reasonable accommodation are not met by the child protection system.
4. **Pay medical expert fees** as necessary to **adequately represent** low income clients.
5. **Train lawyers and other professionals** in the handling of defense of medically complex child protection cases

I would like to support the fund with a tax-deductible contribution of \$\_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

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My check to the Family Defense

☐

Center is enclosed

Please charge my major credit card  
(Visa, MasterCard, AmEx, Discover)

Card #: \_\_\_\_\_

Exp. date: \_\_\_\_\_ CVV: \_\_\_\_\_

# In re Yohan K.

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shared interests, as well as shared values of family, Christian faith, and living charitably. Indeed, K.S. had donated his first full salary to a local orphanage and Teresa had been active in programs providing services for street children in Mumbai and a YWCA program serving battered women and their children.

Shortly after marrying in 2006, K.S. and Teresa both had the opportunity to travel to the United States on a six-month project for a prominent multinational corporation. K.S. had never been to the U.S. and was excited about journeying to a country Teresa described as the land of opportunity, justice, and freedom. Eventually, both Teresa and K.S. were offered permanent positions with American companies, and they began laying down roots for their family, purchasing a condo in Chicago and becoming active parishioners at Holy Name Cathedral. In early 2008, Teresa and K.S. were elated to learn that Teresa was pregnant with their first child, and on October 13, 2008, Teresa gave birth to Marika.

The new parents were overjoyed and Marika became the center of their world. Teresa began working from home. K.S. and Teresa cherished every step of parenting: bathing her, feeding her taking her to the park, comforting her, changing her diapers, reading to her, and traveling with her. In 2010, Teresa and K.S. learned they were expecting a second child. Viewing children as the fulfillment of their marriage, Teresa and K.S. were delighted to learn about the next addition to their family.

## Yohan's Arrival and First Five Weeks

Teresa and K.S. welcomed Yohan on May 1, 2011. Unlike what they had experienced with Marika, the delivery of Yohan was rapid, painful and frightening; Teresa had opted not to have a midwife or painkillers out of concern about potential negative effects on the birth process. K.S. saw Yohan exit the birth canal with the umbilical cord around his neck. Teresa required extensive post-delivery stitching. Yohan was immediately taken to a separate room to stabilize his temperature, and was not returned for nearly six hours. Despite these complications, Yohan's birth was a joyous occasion for the whole family.

K.S. took a month-long leave from work, allowing the family to spend the entire month of May together. During the first few days home, the children were never out of their parents' care. Teresa and K.S. observed several behaviors of Yohan's that concerned them, including random, high-pitched yelps, which would begin and end in a matter of seconds. The parents were also concerned that Yohan, who like Marika was being exclusively breast-fed, seemed to be cluster feeding (*i.e.*, nursing continuously). Several family members, including K.S.'s sister who traveled from India to stay with the family for a week in May, also noticed strange facial expressions; Yohan would have a dazed look, with his eyes rolling up and side-to-side. Aside from these idiosyncrasies, Teresa and K.S. found Yohan to be a very calm baby who was easily consoled.

At a May 18 appointment with Yohan's primary pediatrician, the parents discussed these symptoms. The doctor's only recommendation was to try giving Yohan gripe water if he appeared to be having indigestion or gas. The parents learned many months later, staring or unusual eye focus as well as random irritability can be evidence of seizure activity. This possibility, however, was never discussed with them at the time.

On the evening of Saturday, June 4, Yohan was uncharacteristically

fussy and, most notably, refused to nurse. Yohan fell asleep abruptly, awakening during the night with a yelp and then again refusing to nurse. On the morning of June 5, Yohan nursed as usual, but as the family was preparing to leave for church, Yohan suddenly vomited, something he had never done before. The parents decided that K.S. would take Marika to church while Teresa stayed home with Yohan. The baby nursed again but, in the middle of nursing, he vomited a second time. Teresa was terribly concerned and immediately had the pediatrician's office page the on-call doctor, and then contacted K.S. After K.S. arrived home, a physician returned the call and went through a list of potential symptoms that could indicate a serious underlying medical problem. Confirming that Yohan had none of those symptoms, the parents followed the doctor's advice that an emergency room visit was not necessary. However, they made an appointment for Yohan to be seen at the doctor's office the very next morning.

Following the call with the doctor, Yohan nursed and fell asleep, closely monitored by his parents. While Yohan was still napping, Teresa observed him slightly twitch his left hand and jerk his left leg. Teresa and K.S. video recorded a second brief episode of twitching—this time with his eyes open, exhibiting the now-familiar dazed stare—to show the doctor at the next day's appointment. Teresa picked Yohan up and he seemed fine, nestling his head on his mother's shoulder. Despite two additional episodes of brief twitching during the night of June 5, Yohan otherwise appeared fine, nursed as usual, and actively played on his baby mat.

On the morning of Monday, June 6, Yohan had another episode of twitching on the way to the pediatrician's office. After witnessing an episode of twitching in the examination room, the pediatrician identified the behavior as seizure activity. Teresa and K.S. were dumbstruck by this very first mention of their baby having seizures, and were understandably distressed and worried about the well-being of their newborn baby. Teresa and K.S. accompanied Yohan, who was in stable condition, as he was transferred to CMH by ambulance.

## Yohan's Hospitalization and Accusations of Child Abuse

Yohan and his parents arrived at CMH at approximately 9:30 a.m. on June 6, 2011. While in the emergency room, Yohan continued to have seizures, jerking his left arm and his eyes deviating to the left or right. Yohan's physical exam on admission documented no bruising, contusions, or other external injuries and he had a full range of motion for all of his limbs, with no pain or discomfort.

The hospital conducted CT and MRI scans of Yohan's head, which revealed small collections of blood in the area found between the surface of Yohan's brain and the membranes that line the skull. Based on these findings, even though the CMH neurologist stated that the posterior location of the bleeding was atypical for abuse, CMH's "child protection team" was contacted and the on-call child abuse pediatrician provided a consultation. As CMH physicians would later verify, there were several potential medical explanations for the intracranial bleeds that were never considered during Yohan's hospitalization, including "benign external hydrocephalus" ("BEH," enlarged spaces in the cranium causing fluid collections) and "cortical venous thrombosis" (clotting in the smaller veins).

The next morning, the child abuse pediatrician and a hospital social worker called Teresa to the meeting that would send her heart plummeting into her stomach. They grilled Teresa about whether there had been any accidents that could account for Yohan's intracranial bleeding, and summarily rejected the only possible explanations Teresa could provide, such as incidental contact from baby equipment

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or rough interactions from older sister Marika. The doctor and social worker quickly honed in on their already-formed theory: child abuse. Teresa was crestfallen. She rightly feared that the doctors' premature commitment to a theory of abuse was causing them to ignore potential underlying medical conditions that would then go undiagnosed and untreated. Teresa unequivocally denied ever harming her child or ever having any reason to suspect her husband—a man she knew to be a gentle, kind-hearted, loving parent—of harming their children. Acting as an assertive and proactive advocate for her son's health care, Teresa demanded a second opinion; a demand the parents would repeat numerous times in the ensuing days and weeks, and which was repeatedly ignored by the hospital and DCFS.

Despite receiving consistent accounts from both of the parents and having no reason to suspect abuse aside from the small amount of intracranial bleeding—which is not uncommon in newborns and can result from numerous medical conditions and explanations—the hospital made a report to DCFS of suspected child abuse. On June 8, a DCFS Child Protection Investigator interviewed each parent, during which interview Teresa was tearful and sobbing. Teresa and K.S. each told the investigator that they could not explain what had caused Yohan's medical findings; neither parent had witnessed any accidents or abusive behavior. The investigator found both parents to be cooperative, appropriate, and forthright. Additionally, during the many home visits she would conduct in the coming months, the investigator would observe K.S. and Teresa's interactions with their children to be invariably positive and loving.

During Yohan's nine-day hospitalization, various tests and examinations were conducted, many of which had the primary purpose of identifying indicators to support the theory of child abuse. As to Yohan's ophthalmological exams, the doctor who would ultimately testify at the juvenile court trial claimed there were multi-layer, "too-many-to-count" retinal hemorrhages, left greater than right. However, these findings were inconsistent with the earlier ophthalmological findings by CMH physicians, which revealed scattered retinal hemorrhages in both eyes, right greater than left. In contradiction to the American Academy of Pediatrics' 2007 guidelines for the evaluation of suspected child abuse, no CMH physician ever documented the alleged hemorrhages by either photography or annotated drawings. Moreover, it was undisputed that Yohan had none of the retinal injuries often associated with abuse, such as tearing or folding of the retina.

CMH also conducted investigatory x-ray imaging of Yohan's entire skeletal system. The CMH radiologist reported an irregularity on Yohan's left femur bone, near the knee joint. Teresa and K.S. were informed that this irregularity was possibly a fracture, a diagnosis that did not make any sense to the parents as they had constantly manipulated Yohan's left leg through diaper changes, massages, clothing, and nursing with never a single sign of pain or distress. CMH radiologists would also interpret later imaging as showing "periosteal reaction," or signs of new bone formation, at Yohan's left knee, claiming this finding confirmed a fracture.

During CMH's application of the cast, Yohan's left leg was repeatedly manipulated, with no signs of pain or discomfort from Yohan. Almost immediately, Yohan began kicking his left leg, causing the cast to move below his knee. This activity was so frequent and vigorous that Yohan's leg had to be casted on three separate occasions over the course of two weeks. As numerous medical experts would later testify, includ-



*Ellen Dymph (left) and Melissa Staas (right) provided outstanding legal representation to Teresa G. and K.S., leading to precedential decision.*

ing the State's orthopedist, this behavior is entirely inconsistent with a fracture. During Yohan's hospitalization at CMH, no physician considered the potential presence of rickets, a mineralization deficiency in growing bones leading to inadequate bone formation and which can mimic the appearance of "periosteal reaction" and/or a so-called "classic metaphyseal lesion" (a bone finding some doctors consider to be specific for abuse). Though the most common cause of rickets is vitamin D deficiency, and though many breast-fed babies have vitamin D deficiencies, CMH never tested Yohan's vitamin D levels.

By the third day of Yohan's hospitalization, his seizures had ceased entirely and he began nursing without incident, cooing, and smiling. Subsequent assessments conducted over the next several months showed Yohan to be developing on par with, or even slightly above, his age mates. On June 15, 2011, Yohan was discharged from CMH. Because of the DCFS investigation, however, Teresa and K.S. were not permitted to live with either of their children or have any unsupervised contact with them. Teresa, K.S., and their extended families took heroic measures to minimize the disruption to the children and prevent their placement into non-relative foster care. Teresa and K.S. rented an additional unit in the same building at significant financial cost, where they resided while various family members—many of whom traveled from India—took turns staying with the children for extended periods of time. The heart-wrenching restrictions barring them from living

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with their children anguished Teresa and K.S., and little did they know at the time that these restrictions would linger until October of 2012.

## Parents Finally Receive Some Answers from the Medical Establishment

Teresa and K.S. remained resolute in their belief that their son had underlying medical conditions that the CMH doctors were failing to explore. Through their search for answers, Teresa and K.S. learned about the risks of vitamin D deficiency, which is not only the primary cause of rickets but can also predispose infants to venous thrombosis (clotting in the veins). CMH had refused to test Yohan's vitamin D levels, but July 2011 blood tests the parents obtained from an out-of-town pediatrician on their own showed Yohan to have a "deficient" level, at 13 out of a reference range of 30 to 100. The most common form of rickets for a child of Yohan's age is "congenital rickets," which occurs when the mother has a vitamin D deficiency that is passed on to the fetus. Indeed, the July 2011 blood tests also revealed Teresa to be insufficient for vitamin D (25 out of a reference range of 30 to 80).

In November 2011, the Chief of Pediatric Neuroradiology at Stanford University Medical Center, Dr. Patrick Barnes, became involved in Yohan's case. Dr. Barnes, who is also a pediatric radiologist, has been a professor at both Stanford and Harvard medical schools, and has been ranked by *U.S. News & World Report* as being in the top one percent of physicians nationwide in the specialty of pediatric neuroradiology. He has focused his work on issues of child abuse, and is a co-founder of Stanford's child protection team. Subjects explored in the several hundred peer-reviewed articles and research he has published have included BEH, rickets, and other conditions that can mimic signs of child abuse. After reviewing all of Yohan's imaging studies, Dr. Barnes concluded that Yohan had pre-existing BEH predisposing him to intracranial bleeding that can be triggered by ordinary trivial trauma, birth trauma, medical conditions such as venous thrombosis, or spontaneously. On Yohan's skeletal images, Dr. Barnes observed the irregularity to Yohan's lower left femur bone previously identified by CMH radiologists, but he did not observe a fracture or signs of a healing fracture. Rather, Dr. Barnes observed many classic characteristics of congenital rickets, including irregularities to Yohan's knees, ankles, cranium, and ribs and bilateral bowing to the tibia, radius, and ulna bones.

Also in the fall of 2011, Dr. Christopher Sullivan, Director of Pediatric Orthopedics at the University of Chicago, consulted on Yohan's case. Dr. Sullivan, who has diagnosed at least 1,000 femur fractures throughout his career and has numerous peer-reviewed articles including ones addressing issues of child abuse, reviewed all of Yohan's bone imaging and medical records and concluded that Yohan's knee irregularities were not diagnostic for a fracture. He did not observe any findings consistent with "periosteal reaction," but rather found that the irregularities on Yohan's left knee were consistent with rickets. It was Dr. Sullivan's opinion that Yohan never had a fracture to his left leg.

In December of 2011, pediatric neurosurgeon Dr. David M. Frim, the Chief of Neurosurgery at the University of Chicago who has been formally recognized by local and national entities as a preeminent physician in his field, reviewed Yohan's brain images and medical records. Dr. Frim is an endowed professor at the University of Chicago with a fully-funded research lab. His research and published works have explored conditions involving benign congenital fluid collections, including BEH, and he has authored a textbook chapter on that very

topic. Dr. Frim concluded that Yohan was born with BEH, predisposing him to intracranial bleeding, which can then cause retinal hemorrhages by blood traveling through the subarachnoid spaces that surround the brain, optic nerves, and retinas.

## Teresa and K.S. Unable to Find Justice in the Trial Court

Despite the well-reasoned non-abuse explanations provided by highly-credentialed physicians, the State's Attorney's Office for Cook County proceeded with its petitions asking the Illinois Circuit Court of Cook County to adjudicate Yohan and Marika as abused and neglected children, and to make them wards of the State. Joining the State in its crusade was the Cook County Office of the Public Guardian, which had been appointed to serve as attorney and guardian *ad litem* ("GAL") for Yohan and Marika.

The medical witnesses testifying for the State—the child abuse pediatrician, a pediatric neurologist, a pediatric ophthalmologist, and a pediatric orthopedist—all came from the same hospital (CMH) and had each been board-certified for less than three years. In fact, the child abuse pediatrician was not board certified in child-abuse pediatrics at the time of her "diagnosis" of abuse in Yohan's case. These witnesses, as well as a CMH radiologist called by the GAL, contested the existence of congenital rickets, yet admitted that a full rickets work-up had never been done. The State's orthopedist had never even heard of congenital rickets and his limited knowledge about vitamin D deficiency came not from his medical training, but from his personal experience as a father. Moreover, the State orthopedist timed the alleged "fracture" to have happened *during* Yohan's hospitalization at CMH.

As to the significance of Yohan's diagnosis of BEH, there was no dispute that the existence of BEH can predispose infants to intracranial bleeding. The State neurologist claimed to have ruled-out BEH for Yohan, but then admitted that this conclusion was predicated upon his assumption that Yohan had a femur fracture. The neurologist verified that no doctor at CMH considered BEH during Yohan's hospitalization, and admitted to having very limited familiarity with BEH himself. The State ophthalmologist acknowledged he did not know exactly what BEH was or what specific impact BEH could have on retinal bleeding. The only witness who contested the diagnosis of BEH was a CMH neuroradiologist called by the GAL, but she used a flawed and medically-unsupported diagnostic standard. Additionally, this same neuroradiologist admitted that CMH never evaluated for venous thrombosis in Yohan's cortical veins.

In asking the court to enter findings that Yohan was abused, the State and GAL leaned on the opinions of the State's orthopedist, neurologist, and child abuse pediatrician that the injuries were caused by "external inflicted trauma," with strong implications that Yohan was a victim of so-called "shaken baby syndrome." However, none of the witnesses testified to **non-accidental** trauma—a required element for proving child abuse under the Juvenile Court Act—and they all stated that they were not offering an opinion as to the specific mechanism that caused Yohan's injuries; rather, they opined as to the type of force that **could** cause these types of injuries. Ultimately, all three witnesses based their opinions upon a so-called "constellation of findings," whereby the mere existence of certain medical findings is considered to be indicative of abuse even if there are medical explanations for each alleged injury and even in the absence of an abusive action causing each injury.

Despite finding that the parents were "loving and responsible" caretakers who nurtured their children and attended to all of their needs, and the acknowledgment by the parents that that they had been Yohan's

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# In re Yohan K.

*continued from page 14*

only caretakers, the court deferred to the “constellation of findings” theory promoted by the State’s Attorney and GAL and their witnesses, concluding that what was most indicative of abuse in this case was the number of injuries that existed. Without any basis in law or the evidence of the case, the trial judge concluded that a medical explanation could not be sufficient unless it could explain all three findings. The trial judge ruled that, in the absence of a unitary explanation, abuse was the default explanation. However, in the very same ruling the court concluded that it was unable to identify a perpetrator, thereby betraying an implicit belief that neither of Yohan’s parents had perpetrated any abuse.

## No Conclusion In Sight

The parents and their counsel, exemplary attorney Ellen R. Domphe, were stunned by the court’s ruling. After litigating in this field for many years, Ms. Domphe was dismayed with the court’s finding of abuse, which plainly was unsupported by the evidence. In her professional judgment, the State dismally had failed to meet its burden of proof. It was difficult to face the defeatism of her colleagues who had warned her that she had been “deluding herself” into thinking it possible ever to win a case involving an alleged shaking of a baby in the Juvenile Court of Cook County. There was little time to absorb the defeat, however, as the court quickly scheduled the “dispositional hearing,” a proceeding at which juvenile courts decide the legal and physical custody of the children while the parents remedy the reasons causing the case to enter the court system. At the September and October hearing dates, the DCFS caseworker and the therapists of each of the parents testified unanimously in favor of returning Yohan and Marika to the care and custody of their parents. These recommendations were based upon the parents’ full engagement with the therapeutic services and the absence of any further services for the parents to complete. At the conclusion of the testimony, the State’s Attorney argued that there continued to be “risk” to the children in light of the court’s findings of abuse. The GAL concurred that because they refused to acknowledge that Yohan had been abused, the parents had not received “meaningful therapy.”

This time, the juvenile judge ruled in the parents’ favor, concluding it was not in the minors’ best interests to be made wards of the State, noting that Teresa and K.S. were attentive parents who “[do] the things that parents do to help their children along and accommodate their children and make their lives better.” The judge restored Yohan and Marika to the care and custody of their parents, under an order of protective supervision.

Teresa and K.S. knew without a doubt that the trial judge’s findings of abuse and neglect were plainly wrong. The thought of allowing those findings to stand was difficult to bear. However, having been granted the one ruling that mattered the most to them—full reunification with their children—Teresa and K.S. decided not to prolong the emotional turmoil of the legal proceedings by seeking appellate review of the trial judge’s erroneous abuse and neglect conclusions. The Office of the Public Guardian, as the children’s GAL, however, had a different agenda. Not content with the judicial finding of abuse it had obtained in the trial court, the GAL filed an appeal of the decision returning the children to their parents, asking the Appellate Court to place the children in State guardianship. Now required to respond to an appeal not of their own making, Teresa and K.S. decided to fight for complete vindication. Now represented by Melissa L. Staas and Diane L.



*Jacob W., the child who was wrongly identified as having a skull fracture, see p. 19.*

Redleaf of the Family Defense Center as their appellate counsel, the parents decided to challenge the trial judge’s findings of abuse and neglect by exercising their right to file a cross-appeal.

## Victory

On June 19, 2013, after a grueling briefing schedule, the Appellate Court of Illinois, First District, issued its unanimous opinion resoundingly rejecting the theories pressed by the State and GAL, acknowledging that Teresa and K.S. had been “thrust into a nightmare.” In the landmark holding, the Appellate Court directed that a determination of abusive causation cannot be inferred from the “constellation” of alleged injuries and, moreover, that the State had not satisfied its burden of proof if it is unable to prove that any single injury was caused by abuse. The Appellate Court faulted the State and GAL experts for speculating and generalizing about possible mechanisms of injuries in areas outside of their expertise.

The Appellate Court also faulted the trial court for ignoring many critical facts that could not be reconciled with the theories offered by the State’s Attorney and GAL experts, and for deferring to experts who were less experienced, less qualified, and less credentialed than the parents’ experts in the relevant areas of medicine. The Appellate Court also highlighted key factual errors the trial court had made in its ruling and the deficiencies in CMH’s initial evaluation of Yohan while hospitalized.

Independent of the trial court’s error in entering findings of abuse and neglect, the Appellate Court rejected the GAL’s notion that when there has been an adjudication of abuse, a parent’s therapy cannot be “meaningful” unless the parent acknowledges that their child was a victim of abuse. The Appellate Court instead preserved a parent’s right to “persist in their own belief of innocence of wrongdoing without being declared unable to care for her children.

The Appellate Court concluded by remanding the case “for immediate dismissal.”

The Family Defense Center is pleased to report that the unanimous, well-reasoned, and factually-supported opinion of the Appellate Court will stand not only as a long-overdue vindication for Teresa and K.S.’s family, but as a useful precedent for advocates of wrongly-accused caretakers in complex medical cases.

# Illinois Higher Courts Disallow Medical Opinion Hearsay and Prior Notes of Persons Not Testifying

By Skye Allen<sup>1</sup>

At its simplest, hearsay refers to an “out of court” statement. Hearsay is generally considered inadmissible in court proceedings when it is presented in order to try to prove the truth of a matter. Because hearsay statements cannot be verified and the person against whom the hearsay is offered does not have the opportunity to cross-examine the person who actually made the statement or created the document, it follows that courts of law should not accept hearsay statements unless they have some added reliability. Lawyers and law students learn about many “hearsay exceptions” that can provide this element of reliability, but if a hearsay statement is not within one of these recognized exceptions, it is considered inadmissible into the evidentiary record in virtually all court proceedings.

DCFS hearings are governed by the Illinois Administrative Procedures Act (“APA”), which expressly states that “in a contested hearing, [t]he rules of evidence and privilege as applied in civil cases

*The Family Defense Center has long maintained that the Department of Child Protection investigation file is not admissible as evidence in an expungement hearing.*

in the circuit court of this State shall be followed.” 5 ILCS 100/10-40(a) (West 2008). And as is generally true in all legal proceedings, the APA provides that hearsay evidence is admissible under the Act only in the case of very specific “exceptions.” DCFS has its own rule that provides that the Administrative Law Judge shall have all authority allowed under the Illinois Administrative Procedure Act and that this “authority shall include, but is not limited to, the following: conducting a fair, impartial and formal hearing in which the strict rules of evidence do not apply.” (89 Ill. Admin. Code 336.120 (b)(1)). While this rule is expressly derived from the APA, in practice DCFS has operated as if the APA’s limitations on hearsay do not apply in DCFS expungement hearings challenging indicated findings and in service appeal cases.

The Family Defense Center has long maintained that the Department of Child Protection investigation file (called the “DCP Packet”) is not admissible as evidence in an expungement hearing for a variety of reasons, including that: it is almost entirely made up of hearsay; it does not meet any of the hearsay exceptions; it is prepared in anticipation of litigation; and the appellant does not have the

ability to cross-examine most of the individuals whose statements it contains.

These DCP Packets also commonly include many reports by doctors and others who may have given opinions about the Center’s client to which there is no legal foundation provided in the report on its own. That is, without knowing the credentials of the doctor giving the report or the circumstances under which the report was made, the report should not come into the evidentiary record in a case simply because it is contained in the investigation file.

The Family Defense Center routinely objects to the admission of the DCP Packet into evidence; just as routinely as the Family Defense Center objects, the Packets are admitted by the judges.

Rulings in two recent Illinois appellate cases, however, have provided legal authority for the contention that the DCP investigative Packet, including any medical records or prior investigation records included in that packet, cannot be admitted into evidence without in-person testimony of the person who made those records. Both cases involve appellate court rulings in cases that were affirmed by the Illinois Supreme Court, but in which the evidentiary rulings by the appellate courts were not addressed by the Illinois Supreme Court.

In *In re A.P. and J.P.*, a case that was appealed to the Supreme Court of Illinois, a mother fought, to prevent the State from submitting as evidence letters and reports written by a doctor at the Pediatric Resource Center (PRC) who was not one of her child’s treating physicians. The evidence came from a doctor whose records were prepared for the sole purpose of preparation for litigation against the mother. At the adjudication hearing, these records were presented as vital evidence of the mother’s guilt. *In re A.P. and J.P.* 358 Ill. Dec. (2012) 370, 372-73. The appellate court, however, determined that these records should never have been admitted, as the PRC physician had examined the child on August 19, 2010, but that “the examination was not part of her follow-up medical care.” *Id.* at 374. The physician’s actual report—in which she argued that the child’s burns were most consistent with child abuse—was not issued until November 24, 2010, clearly demonstrating that her report and the other PRC records “were not made in the regular course of business of a hospital or agency, but rather . . . in anticipation of litigation,” making them a violation of the hearsay rule. *Id.*

Likewise, in *Julie Q. v. Department of Children and Family Services* an ALJ “both admitted into evidence and then considered the notes of a non-testifying, former DCFS investigator.” *Julie Q. v. Department of Children and Family Services* 357 Ill. Dec. (2011) 448. Hearsay can be admitted under the Administrative Procedures Act if it “is the type commonly relied upon by the reasonably prudent persons in the conduct of their affairs.” In *Julie Q.*’s case, the hearsay relied upon consisted of notes of a former DCFS employee “regarding the statements of a nine-year-old child with a history of untruthfulness.” *Id.* at 461. The appellate court therefore ruled that that evidence was not admissible under the exception.

These appellate decisions are important milestones on the path to a system of DCFS appeals that requires reliable evidence—and only reliable evidence—to be used against individuals who have been accused of child abuse or neglect.

<sup>1</sup> Skye Allen is a law clerk with the Family Defense Center and a third year law student at Loyola Law School—Chicago.



# My Son Needed Treatment And I Needed Answers, But Instead We Got Accusations And Threats From The Doctors And Hospital I Had Trusted

By Janet V.<sup>1</sup>

“I don’t think you hurt your son; if you tell us your boyfriend did it, you can leave with your son today,” said the hospital licensed clinical social worker, at the Emergency Room where I took my son for treatment. I’ve always respected and trusted hospital professionals; I didn’t expect them to separate me from my son minutes after our arrival, interview me at length, pressure me to blame someone else, and lie to build a child abuse case against me. I especially didn’t expect that a visit to the ER would end up with my son being taken away from my home.

On the morning of July 20, 2012 I woke up next to my son and my partner. I had to go to the bathroom, and so I uttered underneath my breath, “I have to go to the bathroom.” My son heard me and immediately clasped his little hands on my blouse. “No mommy, don’t go,” he cried and threw the worst tantrum to date. He even tore my blouse. I’m a single mother and my son is very attached to me. He was especially clingy that summer because he had just started a new daycare. I was working on helping him become a bit more independent, and although I thought about it twice, because I don’t like to see my baby cry, I left him with my partner while I ran to the bathroom. I even used the bathroom with the door open. I was back in the room in less than two minutes.

I joined my son back on the bed, making sure not to turn on the lights; we weren’t ready to be up and about just yet. I cuddled with my son for about 15 minutes. He was the little spoon of course. Unfortunately, we ran out of time and had to start getting ready for the day. I helped my son climb down off the bed and followed him into the living room. It was there when I first noticed his bloodshot eyes, and tiny scratches all over his face. I initially blamed pink eye. I asked my son, “What’s wrong with your eyes baby?” He looked at me with a confused look. I asked again. “You have an ouchy on your eyes, what happened to you?” “I fell,” he replied, as if telling me that if he had an ouchy, it must have obviously come from a fall. Duh!

I asked my partner what happened; he said that nothing had happened while I was in the bathroom. I woke up my brother, and called my mother, to ask them if anything had happened to my son while they were watching him the previous night. Another one of my goals was to spend more “me” time. I had gone out to dinner the night before and my son had been asleep when I got home. I didn’t get to see him awake before that morning. My mother said she had mopped the floor, so I wondered, “could the cleaning products have irritated his eyes?” Without a definitive answer, and a few hypotheses (none of which included child abuse). I drove to the hospital to get my son treatment and to get answers from doctors to help narrow down the cause of my son’s bloodshot eyes.

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<sup>1</sup> In January 2013, Janet V. was exonerated through the Center’s legal services program. Janet joined the writing group led by Toni Hoy at the Family Defense Center in the spring of 2013. This article is the result of Janet’s work in the writing group.



*Janet V. courageously tells her story at National Reunification Day.*

Moments after admitting my son into the hospital, before figuring out what was wrong him, I was approached by the hospital’s social worker. “We’re concerned about your son’s injuries. The team of doctors thinks the injuries may have been caused by child abuse,” she said, as she asked me to step out of the room to answer “some questions.” I felt uneasy about leaving my son alone with doctors and hospital staff with whom he was unfamiliar when he needed his Mommy the most. However, I had nothing to hide; I wanted to cooperate. There was no one who wanted to figure out what was wrong

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# Janet V.

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with my son more than me, and I was willing to work *together* with the hospital staff to figure out what happened. As a single mother who worked full-time, my son had come into contact with at least five other adults in the preceding 24 hours, including: daycare staff, my brother, my mother, and my partner. So, even though it hurt my heart to leave my son crying and screaming for me not to leave him, I trusted the hospital staff to stay with him to examine him while I was questioned by the social worker.

Full of mixed emotions, I followed the social worker into a small room at the hospital where she interrogated me for about 45 minutes. So many thoughts were going through my mind, as I frustratedly, but politely, answered questions which had nothing to do with finding out what happened to my son. “How did you feel when you first found out you were pregnant? Where do you work?” etc.

I remember feeling anxious to return to my son, and feeling sad and guilty that my son could have gotten hurt without my knowing. I wanted to find out what caused his injuries, but I was in this room away from him, and away from doctors whom I needed answers from. When we finally got to the part of the interview that I felt would be helpful to us in figuring out what happened to my son. I explained that with so many people around my son in the last 24 hours, given my son’s limited verbal skills, and the fact that I didn’t see anyone hurt my son, the truth was that I just didn’t know what



*Mothers like Janet rely on the Center for legal help and help others by telling their stories.*

had happened; but would like to ask the doctors some questions.

I emphasized to the social worker my love for my son, and described our very close relationship in hopes that she would see that I would never hurt my son. I began sobbing when she explained that *if* DCFS was called they could take my son and place him with a relative, and if I didn’t have a relative who would help me he could be placed in a foster home. She told me that she didn’t think I had hurt my son. She told me that *if* I told them that my partner hurt my son, I wouldn’t have to bother with any of this and I could leave the hospital with my son that same day. “She believes me,” I thought. I initially felt grateful and slightly relieved, because she saw that I would never hurt my son. But I felt uneasy about her proposition. As I thought about it a little more, I couldn’t believe it. She was looking for someone to blame rather than trying to find out the truth.

I told her it was unethical of her to offer me a way out of a horrible situation by pointing the finger at another person without any proof. She became a bit upset, and told me she was just trying to help. She left me in the room for another 25 minutes to “clean myself up.”

When I made my way back to my son, a doctor told me that they had *already* called DCFS. I was shocked to find out they had made the decision it was child abuse, because I was under the impression the reason for the “interview” was to find out the truth. The child abuse doctor had also taken pictures of my 2 year old son without my permission while I was being interviewed.

In the same conversation, the hospital staff also led me to believe that I couldn’t leave with my son without being interviewed by DCFS and by detectives. DCFS then told me I could not leave with my son without signing a safety plan. The hospital had my son and me prisoner there until DCFS and detectives were finished talking to me. I also had to wait until my cousin arrived because, from this point on for the next three months I would not be able to be with my son without her supervision. It was 12 hours after my son was admitted into the ER, 6 hours after he was discharged, when I was finally able to leave the hospital *without* my son; he had to leave with my cousin.

I went to the hospital earlier that morning expecting treatment and answers. I chose this particular hospital because their specialty is children’s medical care, and because their child friendly facility takes my son’s mind off the fact that he’s in a hospital. I trusted them to help my son and help me find answers. Unfortunately, my visit to that hospital separated me from my son when he needed me the most.



*Mama Edie Mae Armstrong leads storytelling at National Reunification Day.*



# Our Lives And Our Beliefs In The Justice System— And In The Medical Care System—Were Shattered By A False Allegation By A Child Abuse Pediatrician

By David and Michelle Weidner

## David's Story: Our Ordeal as Wrongly-Accused Parents

Before my wife and I were falsely accused of child abuse, we believed that our justice system worked. We supposed that anyone who got into trouble with the police or DCFS was probably guilty. We quickly learned that our assumptions were wrong. We learned innocent parents are falsely accused at a much higher percentage than we ever thought possible and the system doesn't quickly recognize or correct its mistakes.

I'm a clinical psychologist. I provide faith based-individual and marital therapy in a private practice and I'm also a therapist for the Federal Bureau of Prisons. My wife, Michelle, is a U.S. Air Force veteran, holds a Master's degree, and is currently dedicated to raising our three young sons as a stay-at-home mother.

Our third child Jacob was born in the fall of 2010 and right from birth he had many medical problems. He spent his first 12 days in the neonatal intensive care unit, then was readmitted only two days after he came home. He came home with lengthy IV treatments and many specialist appointments.

When Jacob was only five weeks old, he started vomiting at home and we rushed him to the emergency room. He stopped breathing and was rushed off for a CT scan. We were told he was critically ill; he was admitted to the pediatric intensive care unit. The specialists there were baffled by his symptoms, which included electrolyte abnormalities and severe weight loss. Standing by our baby's crib side in tears, unsure if he would live or die, we were suddenly told that the CT scan showed a skull fracture. We were stunned and very confused. Hospital staff said they were stunned too, because Jacob had no external injury at all. We had no idea what could have happened to our baby.

Right away, DCFS and police investigators came in to question us. It was absolutely traumatic. My wife Michelle could hardly even breathe. Later, they questioned our two older boys, who were just four and six years old. Our sweet boys were so confused and sad about the kinds of questions they were being asked, including whether their parents hurt them.

The hospital's child abuse expert told the DCFS investigators and police that our son had suffered a severe, displaced skull fracture within the previous seven days and that such injuries only resulted from blunt force trauma.

Our world imploded. Because Jacob's treating doctors couldn't unravel his symptoms, suddenly we felt that they had turned the tables on us, insinuating that *we* caused his medical issues. We heard

the label "Munchausen's Syndrome By Proxy"—a claim that *we* had induced Jacob's medical condition. It was a nightmare. No one stood up to the child abuse expert, even though we later learned she had not even passed her child abuse specialty board exams.

DCFS mandated a safety plan under which we were not allowed to ever be alone with our boys. We have no local family, so our friends and family members had to drive and fly in to help. Even so, we were warned that our three sons could be placed in foster care with strangers at any time. We were scared to death. We could hardly eat or sleep.

Within a few days, our son was diagnosed with a rare genetic disease that explained the electrolyte abnormalities and failure to thrive, but the same findings didn't explain the alleged skull fracture, so we were still stuck, unable to live as a family, uncertain of what would happen to our precious children and ourselves.

Two weeks passed. The lead radiologist at our son's hospital, who had been out of town, looked at the CT films and told investigators that **it didn't even look like a skull fracture**. Immediately, the police dropped their investigation. Before we had a chance to breathe a sigh of relief, however, we learned that DCFS was required to keep the case open because the hospital's child abuse expert refused to concur with the hospital's lead radiologist. Criminal child abuse charges were still possible. We decided we

needed to take further action to exonerate ourselves.

## Michelle's Story and the Journey Towards Advocacy

We did feel some relief at having the safety plan lifted so that we could again be alone with our three precious boys. We were comforted that DCFS realized we weren't safety risks to our children. Still, the hospital's child abuse expert refused to admit that she may have made a mistake.

We set on a mission to discount her allegations by uncovering the truth. We took our son to the Cincinnati Children's Hospital, which is nationally ranked third for pediatric neurology. Within 24 hours, the hospital produced a 3D imaging study of our son's CT films which determined that the alleged skull fracture was due to a botched CT scan. Our son Justin had been improperly positioned in the machine, allowing him to move while the scan was being performed. The movement created a motion artifact, which is the clinical term for a "blur," creating the illusion of a skull fracture. In short, there was no fracture *at all*. **Our son's skull had been fine all along.**

Upon returning to our home, every treating physician and investigator now admitted to doubts about the skull fracture and the abuse

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*The Weidners, enjoying being together after ordeal.*

# False Allegation

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allegation from the very beginning. They claimed that they had to leave the investigation in the hands of the hospital's child abuse expert. When we told our son's leading treating physician, he said, "I knew all along there was no fracture, but I don't get involved in these matters."

Even though we were fully cleared of the allegation, it took an additional two long months for the case to be formally closed.

I did my own research about this hospital's child abuse expert. Not only has she not passed her child abuse pediatrics boards, but she has no advanced training in neurology, orthopedics, radiology, pathology or forensics. Despite her limited specialized expertise, her opinion supersedes the specialists in all of these areas. I began to wonder how many other families in our region had been victims of false allegations from this same doctor.

In the last two years, I have discovered at least 12 other families whom I believe were wrongly targeted by this doctor. I'm not alone in thinking that this doctor has terrorized these families; lawyers and other experts also believe she has caused wrongful convictions. In a recent case, a father was acquitted of criminal charges this doctor had levied against him.

The incident involving our son has affected our lives to the core. It was only two weeks that we were fully treated as child abusers, but even this experience violated us and left many scars. In large and small ways, it has changed our parenthood experience. Not a day goes by that I don't think about what happened. Not a single day.

It would have been easy to move on with our lives and leave this nightmare behind us, but we haven't done that. We have been moved to action. Our eyes have been opened to the growing number of parents facing false allegations because a medical misdiagnosis related to their child's illness, injury or death.

**But the situation is not hopeless.** My husband Dave and I, along with many other people, are committed to playing a role in changing this broken system. The road to reform will take time, but we are in it for the long haul. For me personally, becoming an advocate for justice is not a choice but a moral obligation.

After our allegation cleared up, I made a promise to my boys: **I would make sure that this injustice doesn't happen to anyone else.** Keeping that promise to them is my strongest motivation. It is a tall order, to be sure. In fact, as we all know, false allegations continue, but I know that reform will happen and my family will play a role in that. It is our hope that by telling our story, we will give courage to others to share their stories. It is through all of our stories that eyes will be opened to the broken state of our child protection system.



*Toni Hoy, renowned family advocate, moderates panel with Janet V. and E.Z., the Weidners and Mary C. at National Reunification Day.*



# PRIMA FACIE CASE OF “FAILURE TO THRIVE” ENDS IN EXONERATION FOR MOTHER

By Alex Rosney<sup>1</sup>

When a child does not meet the minimum standards of weight for their height and age (i.e., the child's weight is below the third percentile), medical professionals may diagnose the child with “failure to thrive.” Failure to thrive can be either organic—meaning that the condition is believed to have a medical or physical cause—or nonorganic—meaning the causes are thought to be due to the caregiver's actions (i.e., failure to feed the child properly). A diagnosis of non-organic failure to thrive will likely cause child welfare services to be called to investigate whether the child is neglected and whether the parents may maintain legal custody of the child.

The Illinois Juvenile Court Act lists a diagnosis of “failure to thrive syndrome” as one of several diagnosed conditions or syndromes that constitute “prima facie” evidence of abuse or neglect in the Juvenile Court Act (705 ILCS 405/2-18(b)). For a medical diagnosis of nonorganic failure to thrive syndrome to be made, the DCFS Administrative Rules, 89 Ill. Admin. Code 300 Appendix B (#81) require verification that a physician has ruled out medical causes of the child's very low weight. DCFS rules specify that to find neglect due to failure to thrive, the child's weight and head circumference must not match standard growth charts; the child's weight must be below the third percentile or twenty percent below the ideal weight for the child's height and there must be “emotional deprivation” as a result of parental “withdrawal, rejection or hostility.”

In *In re Barion S.*, 983 N. E. 2d 57 (Ill. App. 1<sup>st</sup> Dist., 2012), the mother was able to overcome the presumption of neglect based on a medical diagnosis of non-organic failure to thrive, prevailing in her appeal from a finding of neglect by the Cook County Juvenile Court. (The mother in the case had been assisted by the Family Defense Center in out-of-court advocacy and counseling; the Cook County Public Defender's Office represented her in court).

DCFS began its investigation on March 13, 2010 when Barion's mother, Sabrina, brought him to the hospital for a fever. Hospital staff determined that the baby had lost weight and the hospital staff called the DCFS Hotline to report suspected non-organic failure to thrive. At eleven months old, Barion's weight had fallen below the third percentile. Following the hospitalization that triggered the DCFS investigation, Barion was hospitalized an additional four times allegedly due to malnourishment. DCFS received reports that he was losing weight while in the care of his mother, and it was alleged that there was no medical reason or diagnosis for the weight loss.

DCFS took protective custody of Barion on July 1, 2010 while he was at Stroger Hospital, due to his continued weight loss. There were discrepancies in the medical records, however. Some records from Stroger Hospital stated that Barion tolerated food well, ate eighty to one-hundred percent of his meals, and continued to gain weight



Angela Inzano, Center staff attorney, supports rally for moms led by C.L.A.I.M.

while in the hospital, alleging too that he failed to gain weight when he is with his mother. But Barion's mother Sabrina testified that Barion continued to have difficulty feeding and his weight fluctuated while he was at Stroger Hospital, and she was able to point to contrary hospital records showing Barion ate only thirty to fifty percent of his food, not the much higher percentage. The medical records further showed that Barion was prescribed medicine to treat gastro-esophageal reflux disease (GERD) as a possible contribution to his weight issues. Progress notes signed by a resident and a doctor during Barion's hospitalization identify GERD as a possible cause of his weight loss, showing a medical cause had not properly been ruled out.

<sup>1</sup> Alex Rosney, a third year Loyola Law student, was a law clerk for the Center during the summer of 2012.

# Exoneration

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While hospital staff reported that Barion gained weight only while in their care, three DCFS employees observed Sabrina providing Barion with proper care when she was with her son. Testimony from the caseworkers did not support a finding of neglect. Both the DCFS investigator and the intact case manager testified that the home was clean and that Barion did not show signs of abuse or neglect.

The trial court found Barion was neglected and directed that he be placed into the guardianship of DCFS. The Appellate Court reversed those determinations. While the State was allowed to rely on the failure to thrive diagnosis to establish a prima facie case of neglect, the Court held that the mother presented sufficient evidence to rebut that initial showing. The Appellate Court relied on: Sabrina having repeatedly sought medical attention for her son because he would not eat and often vomited after eating; that she was proactive in seeking help for Barion and took him to multiple hospitals because she did not believe he was being treated effectively; that both case workers' testimony did not support a finding of neglect; that the medical records presented a conflicting basis for Barion's health issues because they suggested an organic basis for his failure to thrive; that GERD was a possible contributing factor to his inability to gain weight; and that the medical records did not show that Barion's eating habits were better at the hospital than at home, or that his weight continued to improve while in the hospital. It held the trial court had improperly relied on medical records containing contradictory information about Barion's feeding in the absence of live testimony that might have reconciled the conflicts in the records.

Unfortunately, Barion's doctors at Stroger had been too quick to blame Sabrina for Barion's failure to thrive and failed to fully explore any underlying cause. Two of Barion's treating physicians suspected GERD, yet dismissed it as a possible organic reason for his failure to thrive. It is troubling that Sabrina was "indicated" for neglect and lost custody of her son when there was no evidence of neglectful behavior on her part.

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## News Briefs

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### Illinois Parent Attorney Network Plans Third Statewide Training

The Illinois Parent Attorney Network, started by the Family Defense Center in November 2011, has held two excellent training programs that have been attended by over 50 attorneys at each session. Building on its 2012-2013 success, the Network is planning its next training at a new location: the DuPage County Judicial Center at 9:30 a.m. on October 25. Once again, Louis Milot, a very experienced trial and appellate attorney from Peoria, Illinois, will be the primary presenter, with the focus on evidentiary issues in juvenile court cases. Kent Dean, a Cook County-based juvenile child protection and criminal defense lawyer, will also present on permanency hearings. A training in February, 2014 on termination of parental rights is also being planned. All attorneys who represent parents in juvenile court or DCFS matters are invited to attend in person or by webcast and to become involved in planning future training programs. Please email [angela@familydefensecenter.net](mailto:angela@familydefensecenter.net) to get involved.

GERD is a common cause of organic failure to thrive. With GERD, the esophagus becomes irritated to the point where the child may refuse to eat because of pain. When Barion took so long to eat and often refused to eat, GERD should have been more actively considered as a cause for Barion's low weight. Barion's vomiting was also a contributor to Barion's weight loss. Sabrina was consistently patient with him and spent up to forty-five minutes trying to feed him. Moreover, Sabrina was proactive in seeking a nutritionist and switching medical providers to treat Barion's vomiting and inability to gain weight. These factors should have been considered all along in rejecting the non-organic failure to thrive diagnosis.

The Appellate Court's decision in *Barion S.* demonstrates that a proactive mother can defeat a prima facie case of neglect due to diagnosed failure to thrive. Hopefully, this decision will encourage doctors, prosecutors and DCFS investigators to more carefully consider possibly medical causes for a child's failure to thrive, especially when it appears that the parent is diligent in caring for the child.



*(From left to right) Exoneree Tabitha Pollock, FDC Staff Attorney Angela Inzano, and exoneree and NFL player Brian Banks at the 2013 Innocence Conference.*



# Can You Believe This? (With A Medical Twist!)

**Sandra**<sup>1</sup> is a proactive advocate for her two boys, “Casey” (age 14) and “Timothy” (age 12). Casey and Timothy have ongoing mental health issues, including severe anxiety for which they require psychiatric care and cannot be in a traditional school setting. DCFS investigated the false claim that boys were not regularly taking their medication or attending visits with their psychiatrist, which the boys’ psychiatrist immediately refuted, Sandra was then berated by the DCFS investigator



for not being “proactive” enough in continuing the boys’ education. Instead of recognizing the children’s vulnerable mental health status, the DCFS investigator also interrogated the boys, demanding to know if they “knew their Mom could go to jail” for not sending them to school regularly. The allegations against Sandra were never clarified and after coming into the home and terrorizing the family, DCFS closed up the investigation with an “unfounded” finding, leaving the family to pick up the pieces of the emotional carnage DCFS’s needless intervention caused. Sadly, we *do* be-

lieve these threats to the children were made, because the same investigator told a mother plaintiff in the *Dupuy* lawsuit, in the presence of her 10 year old son, that her son “masturbates all over the place;” told another teen’s private school that she was using drugs (causing her to lose the school placement she loved); told the grandmother and legal guardian of three to “walk away” from her home when she was having trouble paying her utility bills and threatened another family represented by the Family Defense Center that their 11 year old autistic son would remain on the Child Abuse Registry for 50 years (there is a 5 year or age of 23 limitation on all registries of children). What we *can’t* believe is that an investigator with such a long history of abusive conduct toward children and families remains on her job, free to damage more and more vulnerable children with her cruel and outrageous comments.

After bringing her infant son to the hospital for a suspected fracture to his arm that had been caused by rough handling from an older sibling, a DCFS investigator told our client, “**Melanie**,” that in order for the baby to be released from the hospital, Melanie needed to sign a “safety plan” placing both of her children with a family member. Based on her understanding from the investigator that this was a short-term arrangement that would only last for a few days, Melanie initially had allowed the boys go to the home of her mother despite their strained relationship. When this “safety plan” placement dragged on into a second week, Melanie told the investigator that she objected to the children staying with their grandmother, but the investigator told Melanie that she didn’t have a choice in the matter. The reasons for Melanie’s objection to placement with her mother were, in fact, quite reasonable: (1) the grandmother smoked inside the home; (2) the grandmother refused to give Melanie’s four-year-old son his prescribed medication; (3) the grandmother refused to seek medical treatment for a rash around the infant’s mouth; (4) the grandmother was limiting Melanie’s access to her children; and (5) the grandmother repeatedly told the four-year-old that his mother (our client Melanie) had abused the baby and would be going to jail. After this unacceptable placement lingered into a second month, the Cen-

ter documented Melanie’s objections and demanded that the children should move to another relative’s home immediately while the investigation concluded. Even so, an additional week passed before DCFS took steps to finally end the unlawful “safety plan” with Melanie’s mother. Additionally, DCFS subjected Melanie’s four-year-old son to a custodial interview over Melanie’s objections and repeated disparaging remarks to and about Melanie, such as yelling, “I’m tired of you and your lawyer s\*\*t!” and commenting to a family member that “I don’t know why you deal with [Melanie]—she’s a f\*\*king nutcase.” While we *can* believe that DCFS investigators swear, we *can’t* believe that a DCFS investigator would be stupid enough to swear about the client’s lawyers to a client who very well might sue for civil rights violations.

It is well known that polygraph tests are unreliable and inadmissible in court. But that did not stop a whole team of DCFS investigators and a child abuse pediatrician from basing a decision to “indicate” a father, **David**, on two allegedly failed polygraph questions, including the question of whether he “hurt anyone.” This determination was self-contradictory too, for while the father reportedly failed two questions, he was found to be “truthful” on his answer “no” to the question of whether he had hurt his child. The reliance on the polygraph by doctors who should know better made defending their conduct of the family’s expungement appeal so problematic that DCFS decided to amend its findings rather than face the slew of motions the Center had filed to exclude all of the unreliable evidence DCFS had relied on. We had previously believed that child abuse doctors at least claim to be relying on medical tests, not police interrogation tools, when they reach their medical conclusions that a child has been abused. We can’t believe that a doctor who claims to be an expert in child abuse would base her medical opinion on a polygraph test.

**Eddie** and **Jane** are the parents of a five-month-old son Lloyd and a much larger sixteen-month-old son, Marcus. The boys are cared for during the day by a nanny who comes to their home. One day, as soon as they came home from work and they tried to lift Lloyd, he seemed to be in pain upon being lifted up. The nanny did not know why, but the injury clearly had happened while she had been watching the child. The parents thought that perhaps Marcus had fallen on the baby. After a collarbone fracture was found, the parents were forced out of their own home under a DCFS safety plan, under threats that if they didn’t leave the home and allow a relative to care for their children, the children would be taken from them. Eric’s brother and sister-in-law had to come in to live with the children. The parents had to stay out of their own home for a week and even after being allowed back home, they were not allowed to be alone with their own children. This extreme intervention occurred even though: (a) the injury clearly occurred on the nanny’s watch; (b) there was a possible explanation for how the injury occurred; and the (c) family sought prompt medical attention. We believe that an obviously innocent family like this one can be threatened with separation for no valid reason, including lack of “reasonable suspicion” or “probable cause.” What we didn’t believe until we read it with our own eyes is that one of the leading child abuse pediatricians, Dr. Mark Hudson, who trains other child abuse pediatricians, has written in training materials that collarbone fractures have very low suspicion for abuse and are difficult if not impossible to cause through abusive action. So even the child abuse doctors who cooperated with DCFS in causing the family to live under an onerous safety plan knew or should have known that there was no basis for that demand. In our book, knowingly and needlessly causing harm to a child and his family is a form of child abuse itself.

<sup>1</sup> Names have been changed in this article to protect client confidentiality.

## Message from the Executive Director

### MEDICALLY COMPLEX CHILD ABUSE CASES TOO OFTEN TURN ON MEDICAL DISPUTES, NOT EVIDENCE OF WRONGDOING

Children can and do sometimes get injured in all sorts of ways that loving parents cannot always explain but that do not amount to child abuse. Indeed, that's why parents seek medical attention. Policies that require automatic child abuse reporting of "unexplained" head injuries and fractures are hurting children even though the policies are intended to help prevent child abuse. Just read the stories by Janet V. and the Weidners (pp. 17-20),



among the several dozens we've handled at the Center in the past two years, for compelling accounts of why child abuse reports of medical findings parents can't explain are often hurting children and families more than helping to prevent or treat child abuse.

I've noticed that it's often the most conscientious parents who get tagged with child abuse allegations after a subdural hematoma or commonplace fracture is discovered. That's because a truly abusive or neglectful parent wouldn't have brought the child for medical attention in the first place. I've noticed too that the allegations involving medical injuries labeled as due to child abuse have few obvious class, race or gender components, but that the resources needed to combat these allegations are so substantial that low income families, minorities, immigrants and other disadvantaged parents face a truly unfairly stacked deck when a doctor is accusing them of child abuse based on a medical finding on an x-ray that they cannot explain.

What has happened in our society to explain why excellent parents who are conscientiously caring for their children are being swept into the child abuse investigation net? I think the answer is that the child abuse boogeyman—the fear that anyone may be a child abuser—has gotten the better of us. After many years of successful PR campaigns to promote massive child abuse reporting “when in doubt,” every father and every mother, including a Mother Teresa herself (see lead article p. 1), has become a suspected child abuser as soon as a child's x-ray raises a shadow of a doubt about a child's injury.

I think it's time to stop suspecting every adult of being a secret child abuser. It's time to reconsider the nearly automatic child

abuse reporting policies that sweep parents into the child protection system when they have never done anything wrong, but where their children have medical findings that are sometimes due to abuse but more often not. It's time to stop making “child abuse” a default explanation whenever a child's condition can't be easily understood, is uncommon or wasn't witnessed by an adult.

And it is also time to give a “hats off” to the doctors whose research into medical science is showing that subdural hematomas or retinal bleeding is much less likely due to a shaking than had been assumed. Medical science is starting to uncover many medical explanations for injuries previously thought to be child abuse. See p. 1 article (presenting a number of alternative explanations that leading doctors have researched). Shaken baby allegations have become so dubious as a category that child abuse pediatricians have renamed these allegations “abusive head trauma” in the hope that relabeling will persuade judges that abuse occurs. Rickets and other bone conditions can account for findings previously thought to be abuse. Judges, fortunately, are starting to require more proof beyond a mere assumption that a “constellation” of rare conditions or unusual medical findings adds up to sufficient evidence of child abuse.

No one should have a vested interest in proving parents are child abusers. Let's welcome advances in medicine that help to exonerate the wrongly accused, and let's support the doctors who are leading the way in questioning assumptions that “only child abuse” can cause injuries when good parents are seeking answers about their children's conditions.

Yours in the struggle for justice for innocent families in the child welfare system,



Diane L. Redleaf  
Executive Director,  
Family Defense Center



The Family  
Defense  
Center