What Child Welfare Attorneys Need to Question About the Innocence Project’s Information on Shaken Baby Syndrome/Abusive Head Trauma

We read with some interest Ms. Judson’s recent editorial for the ABA, “What Child Welfare Attorneys Need to Know About Shaken Baby Syndrome” (http://apps.americanbar.org/litigation/committees/childrights/content/articles/spring2015-0315-welfare-attorneys-shaken-baby-syndrome.html). Ms. Judson and the Innocence Project assert that Shaken Baby Syndrome/Abusive Head trauma (SBS/AHT) is a diagnosis that is “fraught with errors”, and “rests on an uncertain foundation”. Presumably supportive of such, they cite a JAMA study from 2012 that states that medical diagnoses “can be delayed, missed, and incorrect” in “10% to 20%” of cases. They infer that physicians have recently learned of alternative diagnoses, such as “accidents” and “illnesses and other nontraumatic causes”, that can mimic the findings commonly seen in SBS/AHT. They conclude by asserting that all professionals involved in these cases should “recognize that it is usually not possible to tell, from medical findings alone, whether a particular injury is the result of abuse or accident”, and should “recognize that diagnoses of abuse are based on ambiguous or uncertain medical findings”. This is a mischaracterization of the current state of medical knowledge regarding SBS/AHT. Certainly, sensationalistic journalism pieces on the subject matter are understandable, albeit uneven and unfortunate. However, given the certainty of tone and inaccuracies of information present in the Innocence Project’s piece, we feel compelled to respond and present child welfare attorneys a more balanced perspective regarding the current state of the science supporting SBS/AHT.

We feel compelled to respond and present child welfare attorneys a more balanced perspective regarding the current state of the science supporting SBS/AHT.

While we agree that there are areas in the understanding of SBS/AHT that still require more research and scholarship, it is important to frame from the outset one universally agreed upon cornerstone (agreed to by even those who are skeptical of some of the diagnostic features of AHT): shaking an infant is dangerous and may result in serious injury or death. The current “controversy” is not related to the dangers of shaking, but the relative confidence that individual medical findings, and combinations of findings, are indicative of SBS/AHT.

Clinical Diagnostic Errors in SBS/AHT

It should come as no surprise to anyone that clinical diagnoses can be “delayed, missed, or incorrect”. The issue is not one of whether clinical diagnoses can be delayed, missed or incorrect, but with what probability. And, more importantly, with what probability are these clinical errors “type 1” errors (i.e., false positives) or “type 2”
errors (i.e., false negatives) in abusive head trauma cases. "Type 1" errors (false positives) would result in child abuse being over-diagnosed, and "type 2" errors (false negatives) would result in child abuse being under-diagnosed.

Towards this determination, the Innocence Project has provided irrelevant and misleading data. The Innocence Project cites Graber et al as a source of a "10–20%" diagnostic error rate. Aside from the obvious hasty generalization of applying a general statistic of "10–20%" delayed, missed or incorrect diagnoses in all clinical circumstances to type 1 errors in SBS/AHT cases, the source itself actually provides the reader with the data to expose the logical fallacy. As the source for their "10–20%" estimate, Graber et al. cite an analysis by Berner and Graber, in which the authors actually report a less than 5 percent error rate for pathology and radiology—two disciplines which are more pertinent in the analysis of suspected SBS/AHT cases. (See Berner E, Graber M, "Overconfidence as a Cause of Diagnostic Error in Medicine", The American Journal of Medicine, Volume 121, Issue 5, Supplement, May 2008, Pages S2–S23, ISSN 0002-9343, http://dx.doi.org/10.1016/j.amjmed.2008.01.001.) Thus, the reference of an error rate of "10–20%" is unrelated to the fields more meaningful in the diagnosis of Abusive Head Trauma.

The more pertinent question is: what can child welfare attorneys know about type 1 errors in SBS/AHT cases from the evidence-based medical literature? The more responsible answer is: that it is difficult to know; the best current data is limited; but, that the data actually points to a high prevalence of type 2 errors (i.e., under-diagnosis). (See Jenny et al, ‘Analysis of Missed Cases of Abusive Head Trauma’, JAMA 281. (7): 621–626.1999—finding that almost 30% of later validated AHT cases were initially missed by medical providers).

As the reader may surmise, in order to assess the actual incidence of type 1 and type 2 errors in a clinical diagnosis, there must be "gold standard" end-point by which to assess prior determinations as errors. And, in any clinical diagnosis, especially in SBS/AHT, this is a debatable issue. Should it be court-based determinations of abuse? Should it be multi-disciplinary team based determinations of abuse? Or should it be only confessed cases of abuse? Or something else? Currently, pediatricians establish that "gold standard" end-point as determinations by multidisciplinary child protections teams (i.e., those involving pediatricians, radiologists, ophthalmologists, pathologists, orthopedic surgeons, social workers, as well as various investigative agencies). As stated above, based upon this end-point, it is widely recognized in the medical community that SBS/AHT is under, not over, diagnosed. (http://www.cdc.gov/violenceprevention/pub/pediatricheadtrauma.html).

Additionally, the Innocence Project has attempted to misguide child welfare attorneys into believing that the SBS/AHT diagnosis is "often incorrect because there are no standard diagnostic criteria"; that the diagnosis can be made with certain findings (subdural hemorrhages, retinal hemorrhages, cerebral edema, or others such as rib fractures, bruising, or abdominal injuries) "either separately or in some combination", "with or without external findings". In essence, it is argued that the absence of a necessary criterion invalidates the diagnosis in general, or, at the minimum, makes it more fallible in each and every particular instance it is considered.

This, unfortunately, betrays an understanding of medical diagnoses, the diagnostic decision-making process, and the variability of presentations in the human body. As is known by any practicing physician, there are many medical diagnoses that don’t have a necessary criterion in order for the diagnosis to be made—congestive heart failure, pneumonia, major depression, ear infections, to name a few. Does that mean those diagnoses are prima facie invalid? Of course not. For example, ear infections can be diagnosed with any of the following criterion: fever, ear pain, a red ear drum, pus or fluid behind the ear drum, and a lack of mobility of the ear drum. Thus, an ear infection be diagnosed with or without "fever"? Yes. Can it be diagnosed with or without "ear pain"? Yes. Can it be diagnosed with or without "a red ear drum"? Yes. Can it be diagnosed with or without "pus or fluid behind the ear drum"? Yes. As is patently clear, the lack of a necessary criterion has no logical bearing upon the validity of the diagnosis. More importantly,
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Pediatrics in Children: Historical Vignette”, portrayal of how pediatric medicine has evolved. Science” is done for effect, but is not an accurate hemorrhage or bruising as being part of a “New other etiologies to subdural hemorrhage, retinal centuried. To portray the clinical understanding of conditions?; 2) What are the probabilities of finding retinal hemorrhages in abuse, accidents, and other medical conditions?; and, 3) What are the probabilities that short falls will result in these subdural hemorrhages, retinal hemorrhages, or death? These more important questions are conspicuously absent from the Innocence Project’s information.

To be sure, researchers have indeed been working on these questions (and many others) over the past few decades. As evidence-based medical knowledge has advanced, gone are the days of isolated case reports or brief case series (as cited by Ms. Judson) as statistically dispositive or even instructive tools. (See Oxford Centre for Evidence-based Medicine, “Levels of Evidence” (March 2009), www.cebm.net/index.aspx?o=1025). Advancements in the technological ability to collate and analyze large pieces of medical data, along with the desire to minimize potential cognitive errors and biases of individual observations, have paved the way for systematic reviews and large prospective studies to guide physicians in the valuative strength of associated findings. Currently, the best evidence-based medical literature permits the following conclusions:

1. That Subdural Hemorrhages are much more common in Non-Accidental Trauma than Accidental Trauma, and this is a statistically significant conclusion reached by numerous well-designed, prospective clinical studies (based upon level 2b evidence, Oxford Center for Evidence-Based Medicine; see Vinchon et al., “Confessed Abuse Versus Witnessed Accidents in Infants: Comparison of Clinical, Radiological, and Ophthalmological Data in Corroborated Cases”, Child’s Nerv Syst. 2010. 26:637, 638–39; Bechtel, et al., “Characteristics that Distinguish Accidental from Abusive Injury in Hospitalized Young

The Evidence-Based Medical Literature & SBS/AHT

Contrary to the inference that physicians have only recently learned of alternative causes for the common findings in SBS/AHT (subdural hemorrhages and retinal hemorrhages), there is actually a long and storied evolution of the SBS/AHT diagnosis. Alternative causes to some of the features of AHT, such as infections, nutritional deficiencies, metabolic diseases, birth trauma, cardiopulmonary resuscitation (CPR), seizures, and accidents have been part of the clinical landscape for decades to centuries. To portray the clinical understanding of other etiologies to subdural hemorrhage, retinal hemorrhage or bruising as being part of a “New Science” is done for effect, but is not an accurate portrayal of how pediatric medicine has evolved. (See Al-Holou et al. “Nonaccidental Head Injury in Children: Historical Vignette”, J Neurosurg Pediatrics. 2009. 3:474-483; Levin AV. “Retinal hemorrhages: advances in understanding”. Pediatr Clin North Am. 2009 Apr;56(2):333-44). In fact, infections have been a known cause of intracranial hemorrhage since the early 1900’s, birth trauma since 1801, and short falls since the early 1990’s. (Schwartz, “Birth injuries of the newborn: morphology, pathogenesis, clinical pathology and prevention”, Hafner publications, 1961; Duhaime et al. “Head injury in very young children: mechanisms, injury types and ophthalmologic findings in 100 hospitalized patients younger than 2 years of age”, Pediatrics 1992;90:179–85). These prior medical investigations formed an initial basis for the associations of subdural and retinal hemorrhages with SBS/AHT, a basis which has only been strengthened by advancing medical knowledge.

The Innocence Project has proffered that, “It can be very difficult, if not impossible, to tell whether an injury was inflicted or accidental by looking at the injuries alone”, providing only a few case reports/case series as supporting evidence for this significant assertion. To those unfamiliar with the extensive medical evidence base girding the SBS/AHT diagnosis, this may appear as “a legitimate public health debate”. However, the proposition that accidents and abuse are impossible to distinguish lacks support in sound, evidence-based medical literature and is logically flawed. In essence, the fallacious argument is, “See, because X is a condition that can possibly cause the symptoms, it is probable that X is the cause; or, because X is possible, that means Y (abuse) is less probable.” A more concrete example is the following: “Acne and chicken pox cause spots on the skin. The fact that the child has acne makes it less likely that the child has chicken pox.” The possibility of one condition offers no meaningful information on its probability, much less on the probability of an unrelated condition. The more appropriate questions for child welfare attorneys are: 1) Based upon the best current evidence-based medical data, what are the probabilities of finding subdural hemorrhages in

The proposition that accidents and abuse are impossible to distinguish lacks support in sound, evidence-based medical literature and is logically flawed.
NACC Featured Member: Taylor Dudley

Taylor is an attorney at the Alliance for Children’s Rights in Los Angeles, where she manages a medical-legal partnership for children in foster care at the Violence Intervention Program at the LA County-University of Southern California Medical Center. Taylor is also an adjunct professor at Whittier Law School’s Center for Children’s Rights. Prior to joining the Alliance for Children’s Rights, Taylor was the postgraduate fellow at the Emory University School of Law Barton Child Law and Policy Center.

Check out Taylor’s brief bio on our homepage or login to view her full profile.

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Consensus in the Medical Community, Motivations, & Moving Forward

So, if the facts are as portrayed—a diagnosis that is “fraught with errors” and “rests on an uncertain foundation”, then certainly the SBS/AHT diagnosis would be abandoned by physicians and their representative medical societies... right? Wrong.

SBS/AHT is a diagnosis that, unfortunately for children, continues to be evident in daily clinical encounters (see Leventhal et al, “Fractures and Traumatic Brain Injuries: Abuse Versus Accidents in a US Database of Hospitalized Children”, Pediatrics. 2010 Jul;126(1):e104-15, citing an annual incidence of 1 in 2000 children less than 12 months old who suffer abusive head trauma and/or fractures).
And, it is a diagnosis that continues to have the resounding support of medical societies. In fact, the following are just some of the medical societies who continue to publicly endorse the validity of the diagnosis through educational or prevention information on their websites:

1) The American Academy of Pediatrics
2) The American Academy of Ophthalmology
3) The American Association of Neurological Surgeons
4) The American College of Radiology
5) The Royal College of Paediatrics and Child Health
6) The Royal College of Ophthalmologists
7) The Royal College of Radiologists
8) The Canadian Paediatric Society

The glaring question for any reader is “why”? Why, if there is overwhelming medical data to the contrary, would physicians and their representative medical societies knowingly perpetuate a flawed or false diagnosis? Perhaps all these societies are biased. Perhaps they all have self-serving motivations that preclude objective evaluation of the scientific literature or individual cases of child abuse. Perhaps they have not adequately or sufficiently evaluated the medical literature on a topic squarely within their expertise. Perhaps they don’t appreciate the significant consequences of the decisions thrust upon them. Perhaps there is some dark pediatric office somewhere where British, Canadian and American pediatricians meet to conspire and concoct different manners by which they can break up families. Perhaps. Or perhaps the medical evidence doesn’t lead to conclusions that are favorable to the Innocence Project or their clients.

Even if the broad swath of “bias” is painted upon all these professionals, then why do the Centers for Disease Control (http://www.cdc.gov/Concussion/pdf/SBS_Media_Guide_508_optimized-a.pdf) and the National Institutes of Health (http://www.ninds.nih.gov/disorders/shakenbaby/shakenbaby.htm) also support the diagnosis? What are their biased motivations? Do they strike the reader as organizations that are frivolous or lax in their evaluations of medical literature underlying medical disease? Are they the types of organizations that are unfamiliar with resolving controversial medical topics, such as whether the MMR vaccine causes Autism (http://www.cdc.gov/vaccinesafety/concerns/autism/) or AIDS denialism (http://www.niaid.nih.gov/topics/HIV/AIDS/Understanding/howHIVCausesAIDS/Pages/HIVcausesAIDS.aspx). We encourage child welfare attorneys to evaluate the medical facts proffered by these organizations.

We conclude by saying that we agree with Ms. Judson and the Innocence Project in one respect: SBS/AHT cases are complex and difficult decisions. But from that tiny thread of commonality there emerges a gulf of difference. We disagree that the best way forward is to jettison the whole concept of SBS/AHT. We disagree that there is “New Science” (in the respect that it is neither “new” nor “science”) which has been uncovered, and which is being ignored or stifled. We disagree with the proposition that the best resolution of these difficult cases results from a diagnostic abstinence that is premised upon fear-based agnosticism. While that would most certainly be favorable to their clients, in many cases, it would not appropriately balance the protections interests of vulnerable children. In fact, the history of our societal evolution has already considered this possibility on the normative “differential”...and we have ruled it out.

Finally, we choose not to seek a solution for these ongoing issues with sensationalistic journalistic pieces or contrived courtroom “battles of the experts”. Instead, as clinical scientists, we will seek resolution in patient rooms and research trials. We will continue to endeavor to improve the science—to seek epigenetic causes and effects of abuse on children (Suderman et al, “Childhood Abuse is Associated with Methylation of Multiple Loci in Adult DNA”, BMC Med Genomics. 2014 Mar 11;7:13), to investigate biomechanisms of injury through innovative technological means (Yoshida et al, “A finite element analysis of the retinal hemorrhages accompanied by shaken baby syndrome/abusive head trauma”, J Biomech. 2014 Nov 7;47(14):3454-8), to conduct multi-center prospective clinical trials on associated variables (Hymel et al, “Validation of a Clinical Prediction Rule for Pediatric Abusive Head Trauma”, Pediatrics. 2014 Dec;134(6):e1537-44), and to review the efficacy of prevention programs (Barr et al, “Do Educational Materials Change Knowledge and Behaviour About Crying and Shaken Baby Syndrome? A Randomized Controlled Trial”, CMAJ. 2009 Mar 31;180(7):727-33). To that end, we welcome (and continue to wait for) the Innocence Project’s financial and professional support.
Join us in Monterey, CA August 25-27, 2015!

We hope you will join us at the 38th National Child Welfare, Juvenile, and Family Law Conference to hear the inspirational story of our Keynote Speaker, Xavier McElrath-Bey, a former foster youth involved in the court system.

Xavier McElrath-Bey is a Youth Justice Advocate with the Campaign for the Fair Sentencing of Youth. He speaks across the nation to heads of organizations, government officials, legislators, juvenile justice practitioners and other stakeholders about the importance of age-appropriate and trauma-informed alternatives to the extreme sentencing of America’s youth. He is also a Co-founder of the Incarcerated Children’s Advocacy Network (ICAN): a national network of formerly incarcerated youth who are committed to creating a fairer and humane justice system for all children.

Xavier was 13 years old he was arrested, charged and later convicted to serve a 25 year sentence in prison for his involvement in a gang related first degree murder. After 13 years in prison he came out with a bachelor degree in Social Science from Roosevelt University and a mission to advocate for poor, disadvantaged and at-risk youth.

Soon after his release he earned a Master of Arts in Roosevelt University’s Counseling and Human Services Program. Prior to his current position with CFSY he worked for Ceasefire as an outreach worker, as a street intervention specialist for Catholic Charities, as the Juvenile Justice Diversion Program Coordinator for Alternatives Inc., and as a Clinical Research Interviewer for Northwestern University’s Juvenile Project — in which he assessed the mental health needs and outcomes of over 800 formerly incarcerated youth.

Much of Xavier’s advocacy work has been highlighted by various media sources and news outlets, such as New York Times, PBS NewHour, Huffington Post, MPR, Al Jazeera America, and others. Xavier also recently delivered a powerful TEDx Talk at Northwestern University, titled “No Child is Born Bad”, in which he shared his childhood experiences of abuse, neglect, incarceration and the unique capacity for change that exists within all children – demonstrating that children should never be defined by their worse act.

View additional information on Xavier and other speakers.
Open in Kentucky!

Certification is now available to the great state of Kentucky. For more information or to apply, please visit the Certification page at www.NACCchildlaw.org or contact Daniel Trujillo, Certification Director at 303/864-5359 or Daniel.Trujillo@childrenscolorado.org.

Civility Promise – Tuscany, Italy

The deadline for CWLS submissions for the Civility Promise seminar (October 3–11) in Tuscany is postmarked by June 1, 2015. We encourage submissions from all CWLS. The contest is for those in the trenches as well as leaders of our top child welfare law offices. The winner will be announced July 1, 2015. Full details can be found in the Certification section at www.NACCchildlaw.org.

New CWLS Seal and Email Banners

We have developed a new certification seal which will appear on all new certificates. It is available for download and print production (letterhead, business cards, etc.). We have also developed banners for email signature blocks and website for additional recognition of our Child Welfare Law Specialists. Files can be found on the CWLS Resources page at www.NACCchildlaw.org (CWLS login is required).

First in State

The NACC would like to especially congratulate the following attorneys that became the first in their states to obtain certification.

**IDAHO**
- Mary Jo Beig
- Elisabeth Carriere
- Amanda Trosclair

**LOUISIANA**
- Ayanna Butler
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- Cathy Ouellette
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Congrats to these new CWLS!

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- Derrick Hensley NC
- Annick Lenoir-Peek NC
- Lauren Vaughan NC
- Francesca Blanco NJ
- Cathy Ouellette OR
I confess that I initially pursued becoming a child welfare law specialist because I enjoyed the academic exercise. A closed-book examination of multiple choice and essay questions based on the seminal textbook, *Child Welfare Law & Practice: Representing Children, Parents, and State Agencies in Abuse, Neglect, and Dependency Cases* (The Red Book), written by practitioners, professors, and scholars whom I already admired seemed pretty cool. Plus, back in 2008 when I committed to this endeavor, the Counsel for Child Abuse and Neglect (CCAN) Office in Washington, DC offered to pay our CWLS exam fees as part of its Court Improvement Program funding, and structured group-study sessions to child welfare lawyers interested in specializing. Seemed also like a no-brainer. Since the summer of 2009 when I became eligible to apply and passed the examination, not once have I regretted it. In fact, I continually reap the rewards, and here’s how.

Our work is hard. I represented children first and parents next, and both roles as an attorney require up-to-date knowledge of local and national law, policy and practice news, and social science—a lot for any area of law. This practice is so difficult because we represent unpopular clients, the so-called delinquents or “brutal monsters” (PDF) (see p. 173) or overburdened agency (see p. 834 n.35), and in turn find ourselves vilified. “How can you represent that parent?” Or, “No placement works for this kid, he’ll probably end up locked up.” Not only are CWLS’s used to these arguments, we’ve come to expect them. Our training has prepared us well. We learn to see the system from the perspectives of the actors engaged within: from social workers and agency counsel to children’s and parents’ attorneys, and the responsibilities that flow from those respective roles.

The Red Book training was my first foray into this complex and interconnected world, describing what I had seen in practice but within the richer, systems context. This grounding, along with the 2011 NACC national conference (PDF), enabled me to articulate in writing the debate around racial bias in foster care (PDF), which is the civil rights problem in our practice.

Because our work is often isolating, becoming a CWLS was instrumental in connecting me to our community. And there, I have found great comfort and power. From listservs to blogs to ABA and NACC national conferences, I feel plugged in to what is trending now in our law and practice. More importantly, becoming a CWLS helped me become a better advocate for the families caught up in an unjust system. And for them, I am always learning to do better.

As a CWLS connected to our community, I feel inspired to contribute. Does my dependency case buck national trends? Does it conveniently comply? How can I effect systems change with this case? Is this the appropriate case? My Red Book training taught me to ask these critical questions, and in turn, I teach them to my students. For the past seven years, I have been a clinical law school teacher, and during this time, my students and I have sought to challenge an unjust status quo that too often separates poor families of color in this country. I have learned to bring representative cases with clients’ consent up on appeal, much to the chagrin and even threats of opposing counsel and trial judges. I have also learned client-centered and culturally-competent lawyering makes their incivility not only worth it, it also makes me a better lawyer and person. Today, I am a CWLS in Washington, DC and Alabama, and I am aiming next for certification in California. It really does help.
National Association of Counsel for Children

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As a multidisciplinary membership organization, we work to strengthen legal advocacy for children and families by:

• Ensuring that children and families are provided with well resourced, high quality legal advocates when their rights are at stake

• Implementing best practices by providing certification, training, education, and technical assistance to promote specialized high quality legal advocacy

• Advancing systemic improvement in child-serving agencies, institutions and court systems

• Promoting a safe and nurturing childhood through legal and policy advocacy for the rights and interests of children and families

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