EXECUTIVE DIRECTOR’S NOTE: NACC is an organization of professionals from multiple disciplines, united by our commitment to what’s best for children and their families. Within that big umbrella are competing viewpoints on key issues in our field, as demonstrated by our recent and ongoing debate on the role of medical diagnoses in child protection cases. Prompted by a post on the NACC ListServe, advocates Diane Redleaf and Melissa Staas wrote this post on the NACC Child Law Blog, which was followed by an article in the April/May 2015 issue of The Guardian by Drs. Sandeep Narang and Christopher Greeley. The article that follows is a response.

We could not agree more with the NACC’s stated goal to “improve the lives of children and families by ensuring that [judicial proceedings related to children] produce justice.” Unfortunately, as NACC members undoubtedly know, judicial outcomes related to child abuse do not always get it right, particularly in cases where medical testimony alone forms the basis for the abuse accusation. Courts, attorneys, and physicians sometimes make mistakes when determining whether a child has been abused and who has perpetrated the abuse. Sometimes this means that a child is not protected from ongoing abuse. Sometimes this means that a child is classified as having been abused when he or she was not, and sometimes this means that caregivers are wrongfully accused of abuse. All of these outcomes are tragic.

In their recent editorial, What Child Welfare Attorneys Need to Question About the Innocence Project’s Information on Shaken Baby Syndrome/Abusive Head Trauma, Dr. Sandeep Narang and Dr. Christopher Greeley strike a tone and assert positions that are hard to reconcile with the facts and the cautionary tone of the article by Katherine Judson, What Child Welfare Attorneys Need to Know about Shaken Baby Syndrome, (available at http://apps.americanbar.org/litigation/committees/childrights/content/articles/spring2015-0315-welfare-attorneys-shaken-baby-syndrome.html), to which they purport to respond.

At the outset, it is important to emphasize that we agree that the controversy is not about whether child abuse is real, or about whether shaking or impacting an infant is dangerous. We agree—and were gratified to see the acknowledgment by Drs. Narang and Greeley— that fair and reliable outcomes for children and families deserve a closer examination of the medical science...
and Greeley—that the controversy rather is about whether abuse can be determined reliably for legal purposes based solely on a cluster of non-specific medical findings. And we are especially pleased to see that Drs. Narang and Greeley acknowledge that the evidence supporting alternative causes of the findings often attributed to Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) is well-established.

In the end, we agree that more and better research is important. But we cannot agree that the current evidence base for the diagnosis is solid, or that any challenges to or criticisms of the medical community’s ability to “diagnose” abuse based on a few medical findings are sensationalist, misguided, or merely the product of “contrived courtroom ‘battles of the experts.’” Fair and reliable outcomes for children and families deserve a closer examination of the medical science than that.

Diagnostic Error

Drs. Narang and Greeley challenge Ms. Judson’s assertion that SBS/AHT “is a diagnosis that is ‘fraught with errors,’ and ‘rests on an uncertain foundation’” and assert that Ms. Judson’s claims rest on “a JAMA study from 2012 that states that medical diagnoses ‘can be delayed, missed, and incorrect’ in ‘10% to 20%’ of cases.” Ms. Judson cited the 2012 JAMA study only for the indisputable and unremarkable proposition that all medical diagnoses are subject to error—and uncomfortably high rates of error—including those with much more solid diagnostic criteria than SBS/AHT. Mark L. Graber et al., Bringing Diagnosis into the Quality and Safety Equations, 308 JAMA 1211 (2012). See also, e.g., Berner & Graber, Overconfidence as a Cause of Diagnostic Error in Medicine, 121 AM. J. MED. S2 (2008).

The “diagnosis” of child abuse—which attempts to determine not only what medical condition or conditions a child has, but also to divine what external factors (actions of third parties), unrelated to medicine, caused those conditions—is likely vastly more error-prone than conventional clinical diagnosis that is limited to identifying conditions afflicting the body. The whole field is made more precarious because of the widely recognized fact that the pathophysiology and mechanism of injury for subdural hematomas, retinal hemorrhages, and cerebral edema (the findings often associated with SBS/AHT) are not well understood. See, e.g., Emerson et al., Ocular Autopsy and Histopathologic Features of Child Abuse, 114 AM. ACAD. OPHTHALMOLOGY 1384, 1394 (2007); Waney Squier, The ‘Shaken Baby’ Syndrome: Pathology and Mechanisms, 122 ACTA NEUROPATHOL. 519 (2011); Christian et al., Abusive Head Trauma in Infants and Children, 123 PEDIATRICS 1409 (2009). And even if the evidence-base were solid and the mechanism well understood, the concern about diagnostic error in child abuse is heightened because “gold standard” diagnostic criteria do not exist.... introducing significant subjectivity into the process...

The concern about diagnostic error in child abuse is heightened because “gold standard” diagnostic criteria do not exist... introducing significant subjectivity into the process...

IN THIS ISSUE:

Shaken Baby Syndrome/Abusive Head Trauma: A Complicated Child Welfare Issue .......................... 1
Child Welfare Law Certification ...................................................................... 6
38th National Child Welfare, Juvenile & Family Law Conference .................. 7
Amicus Curiae: In Re Nykyla McCarthy .......................................................... 8
Membership Matters ................................................................................. 9
National Association of Counsel for Children ............................................... 10
The point of Ms. Judson’s article was not to contend that child abuse teams are never correct in concluding a child was abused. Her point was much more modest: that a diagnosis of SBS/AHT based on medical findings alone is one subject to a significant risk of error, and that it must therefore be approached with appropriate skepticism and caution, particularly by attorneys who have an obligation to protect the rights of children, parents, or persons accused of child abuse.

What makes SBS/AHT diagnoses particularly tenuous is that they are not made for treatment purposes but, rather, are determinations of etiology used for purposes of determining legal actions. A 50 percent error rate may be problematic for treatment of ear infections, but nonetheless something we can live with if we must (while we try to improve it). But a significant error rate—even an error rate well below 50 percent—is absolutely unacceptable when the diagnosis is the primary basis for taking extreme legal action, such as taking children away from their parents or sending caregivers to prison or even death row. Drs. Narang and Greeley simply assume that diagnostic standards that may be necessary and appropriate for medical care are likewise necessary and appropriate for legal purposes. They are not.

Drs. Narang and Greeley then suggest that the error rate in SBS/AHT diagnosis might be lower than in medical diagnosis in general, because the 2012 JAMA article “reports 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.” But this parsing of the data again represents the basic problem with SBS/AHT diagnosis. To say that radiology and pathology do better than average is not to say that SBS/AHT is more reliable than other diagnoses. The comparatively low error rate for radiology and pathology reflects the fact that these specialties do a pretty good job (albeit still not perfect) of identifying and diagnosing medical conditions such as fractures, subdural hematomas, tumors, swelling, and the like. But that is the easy part of SBS/AHT diagnosis. The bigger challenge is taking those specific findings and gleaning from them an external cause of the fracture, the hematoma, the tumor, or the swelling. That is where SBS/AHT runs into trouble. It moves from diagnosis of medical conditions to opinions about etiology—an etiology that presumably explains the actions of an outside actor, as well as his or her state of mind (intent or recklessness), and even his or her identity (based on timing).

New Understandings of Alternative Causes

Drs. Narang and Greeley then engage in a bit of revisionist history when they contend that the medical community has known—and acknowledged—all along about the extensive array of alternative diagnoses, “such as ‘accidents’ and ‘illnesses and other nontraumatic causes,’ that can mimic the findings commonly seen in SBS/AHT.” We are pleased to see that Drs. Narang and Greeley now acknowledge that these alternatives are indeed well-established in the medical literature. But until recently, the child abuse field, including especially pediatrics, failed to recognize those alternatives. Indeed, they officially and expressly rejected the notion that alternatives were realistic possibilities.

In its 2001 official position paper on SBS, for example, the American Academy of Pediatrics...
(AAP) expressly recommended a presumption of abuse whenever a child younger than one year suffered an intracranial injury, and expressly rejected the possibility that the classic findings purportedly associated with SBS could be caused by some of the very alternatives, such as accidents, that Drs. Narang and Greeley now say the medical community has always recognized. See American Academy of Pediatrics Committee on Child Abuse and Neglect, *Shaken Baby Syndrome: Rotational Cranial Injuries—Technical Report* 108 *Pediatrics* 206 (2001). In the late 1990s, the leading child abuse pediatricians in the country collectively signed a published letter declaring that virtually nothing could cause the SBS signs except shaking. See Chadwick et al., *Shaken Baby Syndrome—A Forensic Pediatric Response.* 101 *Pediatrics* 321 (1998). Indeed, until recently, physicians routinely testified that nothing but shaking or shaking with impact could cause the findings present in this type of case. See, e.g., People v. Rene Bailey, Indictment # 01-0490 (Monroe County, NY) TR 1101. (“...these injuries could not have been suffered any other way than a Shaken Child Syndrome.”)(transcript on file with authors).

We are gratified that the field is now shifting and re-recognizing the alternatives (and identifying new ones). The most recent version of the AAP position paper on SBS/AHT, for example, no longer includes the “presumption of abuse” advocated in its 2001 position paper and now expressly recognizes that physicians “have a responsibility to consider alternative hypotheses when presented with a patient with findings suggestive of AHT.” Cindy Christian et al, *Abusive Head Trauma in Infants and Children,* 123 *Pediatrics* 1409, 1410 (2009)! But that shift—and considerable additional research identifying and confirming the so-called mimics of abuse—is indeed new.

The only apparent reason Drs. Narang and Greeley insist that this is nothing new is entirely disconnected from their perspectives or expertise as physicians. Rather, it appears to be because whether the recognition of alternative causes is “new” is something that matters in the legal context when convicted individuals seek new trials based on newly discovered evidence in the form of new scientific developments. Despite Drs. Narang’s and Greeley’s protestations to the contrary, courts that have heard the prominent experts from both sides of this debate (including very recently Dr. Narang himself in *People v. Bailey* in Rochester, NY), have evaluated the evidentiary record and concluded in fact that there is new science undermining previous claims that the classic triad (or its variants) was pathognomonic (exclusively diagnostic of) SBS/AHT. Key examples include *Del Prete v. Thompson,* 10 F. Supp. 3d 907, No. 10 C 5070, 2014 WL 296094 (ND Ill Jan. 17, 2014); *People v. Bailey,* 47 Misc. 3d 355, 999 N.Y.S.2d 713 (Co. Ct. 2014); *Ex Parte Henderson,* 384 S.W.3d 833 (Tex. Crim. App. 2012); *State v. Edmunds,* 308 Wis.2d 374, 746 NW2d 590 (Wis. Ct App 2008).

**Emergence of Legitimate Debate**

The doctors suggest that those who raise concern about the SBS/AHT diagnosis do not want a real discussion of the issues. Citing an article by one of us (Findley et al.), they write that when Dr. Narang sought to “educate” legal readers about the medical issues, “he was criticized for attempting to ‘intimidate’ readers with the ‘voluminous’ scientific literature on the subject matter.” It is unfortunate that Dr. Narang perceived a personal insult by that article, for it was no such personal attack or criticism. The article, which itself included a comprehensive survey of the medical literature, merely asserted that “the sheer volume of this research serves to intimidate those who are not familiar with its methodological shortcomings.” Findley et al. *Shaken Baby Syndrome, Abusive Head Trauma, and Actual Innocence: Getting It Right,* 12 *Holus. J. Health L. & Pol’y* 209, 296 (2012). That article then went about the business of directly engaging Dr. Narang in a discussion about that voluminous literature, precisely to help legal readers better understand it and overcome their natural intimidation by it. It is time to move beyond personal sensitivities and engage in the real hard work of objectively discussing the medical issues and literature.

Drs. Narang and Greeley also take shots at what they characterize as “sensationalist” media accounts highlighting and discussing the emerging recognition of the weaknesses in the scientific foundation for the SBS/AHT diagnosis. But this is not sleaze journalism by irresponsible outlets. These are thoughtful pieces in the *New York Times,* the *Washington Post,* the *Boston Globe,* the *ABA Journal,* National Public Radio, Pro Publica, PBS Frontline, PBS NewsHour, The *ABA Children’s Rights Litigation Committee Newsletter,* and the like. A previous NACC blog post written by two of us (Staas & Redleaf) addresses this issue, and the unwarranted attack on objective media investigations. (https://www.naccchildlawblog.org/child-welfare-law/recent-media-stories-shine-spotlight-on-important-debate-is-shaken-baby-syndrome-a-valid-paradigm-by-which-to-
conclude—a-child-has-been-physically-abused/). It does not advance the cause of learning to dismiss all criticisms as irresponsible and sensationalist.

Drs. Narang and Greeley then contend that there must not be any real doubts about the reliability of the SBS/AHT diagnosis, because so many medical organizations recognize it as a legitimate diagnosis. The list of organizations that recognize it certainly reflects the longstanding traditional acceptance of SBS/AHT as a diagnosis, but it says almost nothing about the reliability of the diagnosis in individual cases or the safety in diagnosing SBS/AHT and initiating legal proceedings on a collection of nonspecific medical findings. No one—and certainly not those organizations—doubts that child abuse is real, that shaking can harm a child, or that medical signs can aid in detecting child abuse. But that is not the point. The point is that it is risky, harmful, and not scientifically sound to claim that doctors can determine the actions and state of mind of an alleged abuser based solely or largely on a collection of poorly understood and nonspecific medical findings. Those medical organizations also certainly recognize ear infection as a legitimate diagnosis. But they no doubt would recognize that the diagnosis is fraught with error—the very point Ms. Judson made about SBS/AHT.

The Improper Substitution of Probabilities for Actual Evidence

Drs. Narang and Greeley contend that they can safely diagnose abuse based on non-specific findings because the literature suggests that subdural hematoma (SDH) and retinal hemorrhages (RH) are more common with abuse than non-abuse, and have a high positive predictive value for abuse. They also take comfort in literature suggesting that such findings and related injuries are rare in short falls. Putting aside the many methodological problems with the research that makes those claims (such as universally recognized problems with circularity in the inclusion criteria employed by the studies), the rarity argument cannot do the heavy lifting that Drs. Narang and Greeley assign it. Statistics represents aggregate tendencies, not individual case findings. The responsibility of the legal system is to determine causation and responsibility in individual cases. There is nothing in these statistical probabilities that proves what happened in any individual case.

To the contrary, the data cited by Drs. Narang and Greeley show that none of the diagnostic criteria they rely upon are exclusively diagnostic of abuse, and that, for example, short falls can produce these same findings and injuries (and even death). That data therefore confirms Ms. Judson’s original point—that we simply cannot exclude those alternative possibilities based solely on the presence of the supposedly tell-tale findings. It is not enough to simply defer to a doctor’s “diagnosis,” when it turns out to be a probabilistic assessment that routinely eliminates alternatives based simply on a belief that they are rare, with no real evidence to prove that the individual case under consideration is not, in fact, that rare case.

Most importantly, the duty child welfare attorneys owe to their clients is simply not fulfilled by an analysis of probabilities. The NACC’s Recommendations for Representation of Children in Abuse and Neglect Cases state that the child welfare attorney must perform a full and independent case investigation. (NACC Recommendations for Representation of Children in Abuse and Neglect Cases – 2001 – page 8.) A thorough investigation includes looking deeper than probabilities and critically examining all of the medical and non-medical information that led to the diagnosis of SBS/AHT, particularly since the NACC recognizes that children need family relationships, and therefore recommends that attorneys advocate for continuation of familial relationships and family preservation services where appropriate. (NACC Recommendations for Representation of Children in Abuse and Neglect Cases – 2001 – page 9.)

Toward a Shared Commitment to “Getting it Right”

Finally, in pursuit of factual accuracy, response is required to the attempt by Drs. Narang and Greeley to set up the Innocence Project as their nemesis. It should be made clear that, while Ms. Judson is a clinical instructor with the Wisconsin Innocence Project at the University of Wisconsin Law School, she has made no pretenses of speaking for the Innocence Project. The Innocence Project is an independent non-profit organization affiliated with the Cardozo Law School at Yeshiva University in New York City. The Innocence Project takes on individual representation in which DNA can be used to prove innocence—and of course, forensic DNA profiling plays no part in SBS/AHT cases. Many other independent innocence organizations, including the Wisconsin Innocence Project, with which Ms. Judson is affiliated, do handle SBS/AHT cases. But The Innocence Project does not.
and there is no monolithic organization that does. There is no boogey man here.

Nonetheless, many of us, including some who work with various innocence organizations, do have serious concerns about the weaknesses in the evidence base for SBS/AHT and errors in its diagnosis. Ms. Judson’s article simply cautioned that lawyers handling these cases approach the science with caution and appropriate scrutiny. Why that is objectionable is hard to imagine.

In the end, Drs. Narang and Greeley call for cooperation from other members of the Innocence Network, including the Innocence Project in supporting research to expand our knowledge about SBS, AHT, and the alternative conditions that may present with the findings often associated with SBS/AHT. While we cannot speak for the Innocence Project, we and many others who have represented or supported parents, caregivers, children, and families caught up in allegations of SBS/AHT join wholeheartedly with Drs. Narang and Greeley in this call for more and better objective research into the difficult issues presented in this field. To that end, we believe that a thorough and objective assessment of the science, the law, and the interplay of the two in SBS/AHT cases by the National Academy of Sciences (NAS) is warranted. What is needed to enable this objective inquiry is funding. We and our colleagues pledge to work to raise the funding for such an inquiry. We call on Drs. Narang and Greeley and their colleagues in the child abuse prevention community to join us in that pledge.

» Complicated from previous page

Congrats to out new CWLS!

Jessica Smith CA

CWLS Nominate Next Wave of Specialists

Last month, we asked our Child Welfare Law Specialists to identify the rockstars in their community that NACC should seek out and invite to apply. Each of these nominees will receive a partial scholarship to apply for the program. A big thank you to our CWLS that submitted a name and congrats to those below that made the cut! Our CWLS think highly of you and we hope that you choose to join their ranks.

Collin Baker CA
Linda Beecher AL
Shayla Blankenship MI
Danica Carman TX
Jessica Coalter LA
Melanie Cranford NC
Ann Draper TX
Alice Emerson TX
Jesica Fellman CA
Justin Grubbs GA
Daniel Gubler UT
Jamie Hamlett NC
Courtney art AZ
Shauna Hill GA

Amanda Kennedy CA
Deborah Liverence AZ
Emily Madden DC
Jennifer McCartney CA
David Meyers CA
Kate Nolen MO
Cara Nord CO
William Rayburn TN
Amanda Sherwood CA
Nicholas Talarico CO
Steven Trujillo AZ
Elahna Weinflash NJ
Andraya Whitney AZ
Join us in Monterey, CA August 25-27, 2015!

You don’t want to miss the annual luncheon featuring 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.
to a TPR as a factor. Rights (TPR) and should weigh a child’s opposition to the child prior to entering a termination of parental rights. Additionally, a number of the children have reunited with their biological parents once they age out of the system and have no place to go. When a child is not adopted they are left in “legal limbo” and are “likely to experience post-termination changes in placement.” When the decision is between placing a child in legal limbo by terminating parental rights and continuing to work with the family, it often is in the best interest of the child to work with the parents to stabilize the family unit. Currently neither the Michigan Supreme Court nor Court of Appeals have issued an opinion that requires juvenile courts to consider a child’s views prior to terminating parental rights. Additionally, there is no opinion from either court that requires courts to find termination is not in the best interest of the child when the child, especially an older child, objects, unless the court finds a compelling reason to override the child’s objections. Overturning In re McCarthy would say that courts should consider the age of the child when determining the child’s best interest.

1. Amici Curiae Brief Of the Legal Services Association of Michigan, et al., In re Nykyla McCarthy, 495 Mich. 959, 843 N.W.2d 558, 2014 WL 1002182 (Mich. 2014), which terminated a mother’s parental rights despite the child’s wishes and the GAL’s recommendation not to terminate. The brief argues that courts should consider the age of the child when making the best interest determination. The termination of parental rights is fundamentally different for an older child than for a younger child. An older child without a parent is less likely to be adopted out of foster care and there is a higher risk that the older child will suffer greater harm, as they are more likely to remain in foster care until they age out. Currently, Michigan has the second highest number of children aging out of the foster care system in the country. According to one study, of the children aging out in Michigan, 50% had a mental health diagnosis, only 35% had a high school diploma, and over 30% had experienced homelessness. Additionally, a number of the children have reunited with their biological parents once they age out of the system and have no place to go. When a child is not adopted they are left in “legal limbo” and are “likely to experience post-termination changes in placement.” When the decision is between placing a child in legal limbo by terminating parental rights and continuing to work with the family, it often is in the best interest of the child to work with the parents to stabilize the family unit. Currently neither the Michigan Supreme Court nor Court of Appeals have issued an opinion that requires juvenile courts to consider a child’s views prior to terminating parental rights. Additionally, there is no opinion from either court that requires courts to find termination is not in the best interest of the child when the child, especially an older child, objects, unless the court finds a compelling reason to override the child’s objections. Overturning In re McCarthy would say that courts should consider the age of the child when determining the child’s best interest.

1. Id. at 5.
2. Id. at 6.
3. Id. at 7.
4. Id. at 8.
5. Id. at 9.
6. Id. at 10.
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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