THIS APPEAL AND CROSS APPEAL INVOLVE A QUESTION OF CHILD CUSTODY, ADOPTION, TERMINATION OF PARENTAL RIGHTS, OR OTHER MATTER AFFECTING THE BEST INTERESTS OF A CHILD

No. 1-12-3472

In the
Appellate Court of Illinois
First District

IN THE INTEREST OF:	)	**Appeal from the Circuit**
	)	**Court of Cook County,**
YOHAN K. & MARIKA K.	)	**Illinois, Juvenile Justice**
Minors-Respondents-Appellants/Cross-Appellees	)	**and Child Protection**
	)	**Department, Child**
(PEOPLE OF THE STATE OF ILLINOIS,	)	**Protection Division**
Petitioner,	)	
	)	**Nos. 11 JA 512**
v.	)	**11 JA 513**
	)	
K.S.,	)	**Hon. Bernard J. Sarley,**
Father-Respondent-Appellee/Cross-Appellant	)	**Judge Presiding.**
	)	
TERESA G.,	)	
Mother-Respondent-Appellee/Cross-Appellant).	)	

BRIEF AND APPENDIX OF THE PARENTS-APPELLEES AND CROSS-APPELLANTS TERESA G. AND K.S.

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Oral Argument Requested

POINTS AND AUTHORITIES

NATURE OF THE CASE

K.S. and Teresa G. are the parents of Marika K., born October 13, 2008, and Yohan K., born May 1, 2011. Following a complicated delivery, Yohan exhibited unusual behaviors during his first five weeks of life, including episodes of staring and random bursts of yelping. On June 6, 2011, Yohan had observable seizures and was brought to Children's Memorial Hospital ("CMH"), where he was found to have intracranial bleeding, hemorrhaging to both retinas, and an irregularity to his left femur. Based upon these findings, the Illinois Department of Children and Family Services ("DCFS") launched an investigation, giving rise to the juvenile court proceedings in the court below. During the adjudicatory hearing, doctors from the University of Chicago and Stanford University testified that Yohan had a pre-existing medical condition called "benign external hydrocephalus" ("BEH") predisposing him to intracranial bleeding, including retinal hemorrhages. Additionally, these doctors testified that Yohan did not have a fracture to his left femur; rather, the irregularity on the x-rays was consistent with a diagnosis of congenital rickets—a diagnosis that was corroborated through other radiological findings and a vitamin D deficiency. The CMH doctors that testified as witnesses for the State of Illinois opined that due to the number of alleged injuries, the most likely cause of the intracranial bleeding, retinal hemorrhages, and alleged femur fracture was external inflicted injury.

While finding that the parents were "loving and responsible parents" in its August 1, 2012, adjudicatory ruling, the trial court found that Yohan had sustained a fracture to his left femur and that he did not have rickets. The court did not dispute the diagnosis of BEH, but reasoned it was unlikely Yohan would have a medical condition causing intracranial and retinal bleeds simultaneous to a fracture. This reasoning led the court to conclude the State had met its burden of proving that Yohan had suffered non-accidental

inflicted trauma (*i.e.*, physical abuse), and that both Yohan and his sister Marika had been neglected due to an injurious environment, and abused due to substantial risk of injury. The court declined to identify an abuse perpetrator, stating that it was unable to do so.

Following a dispositional hearing that concluded on October 30, 2012, the trial court found that both Teresa G. and K.S. were fit, willing, and able to care for their children. In its ruling, the court noted that Teresa G. and K.S. are attentive parents who do all of the things that parents do to better the lives of their children.

The guardian *ad litem* ("GAL") for the minors filed an appeal from the part of the August 2012 adjudicatory ruling that declined to name a perpetrator. The GAL also appealed from the October 2012 dispositional order restoring Yohan and Marika to the custody of their parents and seeks to have the children placed in the custody of DCFS. Teresa G. and K.S. filed a cross-appeal, challenging the trial court's adjudicatory finding that their children had been abused and neglected.

ISSUES PRESENTED FOR REVIEW

1. Was the trial court's finding of abuse erroneous because the manifest weight of the evidence established that Yohan had a pre-existing medical condition predisposing him to intracranial bleeding, that Yohan had a history of medical complications from birth, that Yohan sustained no fracture, and that the only doctors who testified to inflicted trauma applied a standard of insufficient professional certainty, whereas the doctors who testified to medical explanations included nationally pre-eminent medical experts?
2. Did the trial court err in concluding that Yohan sustained non-accidentally inflicted injuries where no mechanism of injury was identified and the court was unable to identify *any* abusive acts by either of Yohan's parents?

3. Was the trial court required to identify a perpetrator of abuse, contrary to 705 ILCS 405/2-21?

4. Did the trial court err in finding Teresa G. and K.S. fit, willing, and able and returning the children to their custody where all of the witnesses, including DCFS, supported returning the children to their parents?

JURISDICTION

Parents adopt the GAL's jurisdictional statement, GAL Br. 2, and in addition state that on December 7, 2012, Parents filed a timely notice of cross-appeal. A.8-11.

STATEMENT OF FACTS

A. Familial Background

K.S.[1] and Teresa G., parents of Marika K., born October 13, 2008, and Yohan K., born May 1, 2011, have been married since 2006. R9.84, 94, 113.[2] Both K.S. and Teresa G. grew up in India, each in loving, close-knit families that emphasized values of honesty, equality, integrity, and social justice. R9.15, 64, 66, 70, 222, 224. Upon receiving high scores on his college entrance exams, K.S. attended a reputable engineering school in Bangalore, graduating in 2002 with a bachelor's degree in electronics and communication. R9.72-73. After college, K.S. lived with his parents and his sister, Rashmi, while working as an engineer, R9.75, donating his first full salary to a local orphanage, R9.77.

In 2004, K.S. and Teresa G. met while they were both working as software engineers for a multinational information technology consulting company. R9.77, 79, 231-

[1] Because the father's first name is the same as the children's last name, his first and last initials will be used. Ill. S. Ct. R. 660(c), 341(f).

[2] Parents are utilizing a system of record citation compatible with the system from the GAL's brief and with the Index to the Record on Appeal, GAL Br. A.1-13. The volumes of the transcript records are cited herein as "R#.#," the volumes of common law are cited herein as "C#.#," and the volumes of exhibits are cited herein as "E#.#."

32. Teresa grew up in Mumbai and lived with her family until she was 22 years old. R9.222-23. While pursuing her degree in computer engineering at Mumbai University, R9.230, Teresa became involved in a program providing services for street children in Mumbai and also worked with her mother, Fatima G., R9.12, at a YWCA program serving battered women and their children. R9.17, 225, 227. In addition to K.S. and Teresa's shared interests in reading and travel, R9.483 as well as their shared values of family, religion, and living charitably, R9.41, Teresa was drawn to K.S.'s intelligence and gentleness. R9.232.

Shortly after their marriage, in 2007 K.S. and Teresa both had the opportunity to travel to the United States on a six-month project for Kraft Foods. R9.85, 233. K.S. had never been to the U.S. but was excited about journeying to a country Teresa described as the land of opportunity, justice, and freedom. R9.85, 234. Both Teresa and K.S. were soon offered permanent positions with American companies, and in 2008 they moved to their current residence on Lakeshore Drive. R9.91, 235. They became active parishioners at Holy Name Cathedral, attending services at least weekly. R9.92, 236. In early 2008, Teresa and K.S. were elated to learn that Teresa was pregnant with their first child, R9.94, 237-38, and on October 13, 2008, Teresa gave birth to Marika, R9.94, 98, 238. Teresa and K.S. were overjoyed; Marika became the center of their world. R9.98, 241.

Teresa began working from home, R9.244-45, and she breast fed Marika exclusively for the first several months. R9.100, 204. When Marika was fussy, K.S. and Teresa would try nursing, changing her diaper, soothing her, walking with her, and singing to her. R9.108, 241. They cherished every step of parenting: bathing her, taking her to the park, comforting her, changing her diapers, reading to her, and traveling with her. R9.100, 242-43. In 2010, Teresa and K.S. learned they were expecting a second child. R9.103, 245.

Teresa and K.S. viewed having children as the fulfillment of their marriage, R9.237, and they were very happy to learn about the next addition to their family. R9.107, 245.

B. Yohan's Birth; His First Five Weeks Up To the Day Before Hospitalization.

Shortly after midnight on May 1, 2011, Teresa began having contractions. R9.113, 248. In contrast to the labor and delivery they had experienced with Marika, Teresa's delivery of Yohan was precipitous (rapid) and extremely painful. R6.73, R9.116, R10.219. K.S. saw Yohan exit the birth canal with the umbilical cord around his neck, and Teresa sustained severe tearing requiring extensive stitches. R9.117, R10.219. Yohan was taken to a separate room to stabilize his temperature and was not returned for nearly six hours. R9.120, R10.66-67. Despite these complications, Yohan's birth was a joyous occasion for the whole family. R9.117-18, 122, R10.219, 75; *see also* Parents' Group Exh. 34, E14.120-21 (photos of family in the hospital following Yohan's birth).

On May 4, the Parents took Yohan to an appointment with Dr. Chandra-Puri, scheduled to monitor Yohan's decreasing weight. R6.75, R9.125-26, R10.72. The Parents were advised to bring Yohan for another appointment on May 6, R6.77, R9.131, R10.82, by which time Yohan had gained several ounces and another follow-up visit was set for May 18. R6.78-79. During this same period, Teresa and K.S. observed several behaviors that concerned them including random, high-pitched yelps, which would begin and end in a matter of seconds. R9.134-35, R10.84-85, 99, 100, 104. Teresa and K.S. were also concerned that Yohan, who like Marika was being exclusively breast-fed, seemed to be cluster feeding (*i.e.*, nursing continuously). R9.132-33, R10.83. The Parents had also noticed strange facial expressions, where Yohan would appear as though he was looking through them and not at them. R10.85. At the same time, Teresa and K.S. found Yohan to

be a very calm baby, who was easily consoled, R10.236, 238, and who cried less than Marika had done. R9.132, R10.85.

K.S. had taken a leave from work and was home with Teresa and the children during the entire month of May. R9.133. On May 9, K.S.'s sister Rashmi came to stay with the family for a week. R8.206, R9.136; *see also* Parents' Group Exh. 32, E14.119 (photos taken during Rashmi's visit). Rashmi observed Yohan's unusual expressions, where he would have a dazed look with his eyes rolling up and side-to-side, which they all affectionately referred to as "drunk old man expression" or "dazed and confused." R8.211-12, R9.142-43, R10.90, 99, R11.22. As the Parents later learned, staring or unusual eye focus as well as random irritability can be evidence of seizure activity. R2.168,181, R8.37.

At the May 18 appointment with Dr. Chandra-Puri, Teresa and K.S. described these symptoms. R9.144, R10.90, 98. The high-pitched yelps, which occurred two or more times each day, R9.106, R10.104, were never a source of frustration for the Parents, but they were a source of concern. R10.105. Dr. Chandra-Puri recommended that if Yohan appeared to be having indigestion or gas, they could try some gripe water. R6.80.

On the evening of Saturday, June 4, Yohan was uncharacteristically fussy and, most notably, refused to nurse. R9.148, R10.100-01; *see also* State's Exh. 1, CMH medical records ("CMH Records"), E8.181. Teresa and K.S. tried giving Yohan gripe water and tried soothing any intestinal distress by massaging his tummy with gas-reducing remedies. R9.148-49, R10.107. Yohan fell to sleep abruptly, awaking during the night with a yelp and then again refusing to nurse. R9.149, R10.108, 110-11. 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. R9.149-50, R10.112-15.

K.S. took Marika to church and Teresa stayed home with Yohan. R9.151, R10.115. Yohan nursed again, but in the middle of eating, he vomited a second time. R10.117. Teresa immediately called the pediatrician's office and paid to have the on-call doctor paged, R10.111, then contacted K.S., who departed for home. R9.151, R10.118. After K.S. arrived home, a physician returned the emergency call and went through a list of potential symptoms. As Yohan had none of these symptoms, the Parents followed the doctor's advice that an emergency room visit was not necessary, though they made an in-person appointment for the very next day. R9.153-54, R10.119-24, 133.

Following the call with the physician, Yohan nursed and fell asleep, closely monitored by his parents. R10.131. While Yohan was still napping, Teresa observed him slightly twitch his left hand and slightly jerk his left leg for a few seconds. R10.132-33, 144. Teresa retrieved K.S. and they video recorded a second brief episode of twitching—this time with his eyes open, exhibiting the now-familiar dazed stare, as well as twitching of the left eye—in order to show the doctor at the next-day's appointment. R10.132-35, 144. Teresa picked Yohan up and he seemed fine, nestling his head on his mother's shoulder. R10.144. There were two additional episodes of twitching the night of June 5, but Yohan otherwise appeared fine, nursed as usual, and played on his baby mat, moving his arms and kicking his legs. R10.145-46.

On the morning of Monday, June 6, Yohan had another episode of twitching on the way to the pediatrician's office. R9.156, R10.145. They arrived at approximately 7:45 a.m. R9.157, R10.148. After the nurse witnessed an episode of Yohan twitching, she retrieved Dr. Chandra-Puri who identified the behavior as seizure activity. R6.86-87, R9.158-59, R10.148. Teresa and K.S. were stunned at this first mention of a seizure and the news caused distress, worry, and concern for their newborn son. R9.159, R10.150. An

ambulance arrived, and Teresa and K.S. accompanied Yohan, who was in stable condition, R6.87, as he was transferred to CMH. R9.160, R10.151.

C. Yohan's Hospitalization, June 6, 2011–June 15, 2011

Arrival at Children's Memorial Hospital . Yohan and his parents arrived at CMH at approximately 9:30 a.m. on June 6. CMH Records, E10.228. Yohan continued to have clinical seizure episodes—meaning seizures with observable manifestations—with left arm jerking and eyes deviated to left or right. CMH Records, E8.181; R2.165-66. Yohan's physical exam on admission documented no bruising, contusions, or other external injuries, and noted a full range of motion for all extremities, with no pain or discomfort. E10.232; R9.162-63, 178, R10.155-56. Two additional physical exams on June 6, at approximately 2:40 p.m. and 6:40 p.m., noted full range of Yohan's extremities with no mention of pain, discomfort, or tenderness. E8.2-4, E11.249-50.

Initial Cranial Imaging of June 6, 2011. A CT scan and a subsequent MRI scan were taken of Yohan's head. R8.113, R5.66; People's Exh. 2, CMH Radiology Reports, E12.134-35 (CT Report); CMH Records, E8.240 (MRI Report). The CMH reports for both scans described the existence of small, bilateral, extra-axial, posterior fluid collections, which the MRI report noted was likely representative of small subdural hematomas. E12.134-35 (CT); E8.240 (MRI); R8.112; *see* attached Glossary, A.14, for relevant definitions. Both June 6 CMH reports also noted the existence of a suspected left frontoparietal hemorrhage, E12.134-35, E8.240, later identified as a likely subarachnoid hemorrhage. CMH Radiology Reports, E12.127 (June 9 MRI); *see* Glossary, A.14.

Neuroradiologist Dr. Burrowes read Yohan's June 6 MRI and concluded that a contrast venogram was clinically indicated in Yohan's case, and her June 6 report recommended it. E8.240; R8.170. CMH never conducted a venogram with contrast,

R8.170-71, and no CMH radiologist ever evaluated for presence of clotting in Yohan's cortical veins, R8.169.

Dr. Burrowes' report for Yohan's June 6 MRI also noted no hemorrhage in the brain ventricles and no restricted diffusion. E8.240; *see* Glossary, A.13. She subsequently authored an addendum, correcting her mistake and noting the existence of "restricted diffusion" on the June 6 MRI. E8.240; R8.171.

Suspicions by CMH of Abuse. Based on the June 6 MRI report, CMH's Child Protection Team was contacted. CMH Records, E10.233. Dr. Kristine Fortin provided a consultation in her role as a child abuse pediatrician. R4.9. On the evening of June 6, Dr. Fortin had an initial 15-20 minute conversation with Teresa. R9.164, R10.172-73. The next morning, Dr. Fortin had another interview with Teresa, at which time Teresa was asked if she or K.S. had "done" something to Yohan. R10.179-80. Teresa was shocked and concerned that Yohan had an underlying medical condition that was not getting diagnosed. R10.188. Teresa denied ever harming her child and requested a second opinion. R10.189. Later that same morning, Dr. Fortin separately interviewed K.S. R4.36, 135-38, R9.165-66. Teresa and K.S.'s separate accounts were consistent with one another, and Dr. Fortin found both parents to be appropriate in their responsiveness to Yohan's medical needs. R4.139-42.

Later that same evening, Dr. Fortin informed the Parents that CMH was making a report of suspected child abuse to DCFS. R4.136, R9.167-68, R10.191. On June 8, DCFS Investigator Carolina Bono interviewed each parent. R2.74-76. Both parents were compliant and cooperative, and told Investigator Bono that they could not explain what had caused Yohan's medical findings; neither parent had witnessed any accidents or any

abusive behavior. R2.76-78. Investigator Bono found both parents to be appropriate and forthright; Teresa G. was tearful and sobbing during the June 8 interview. R2.57, 63-64.

In-Patient Treatment and Assessments. Following the June 6 MRI, an EEG was connected and Yohan was noted to have sub-clinical (meaning not outwardly observable, R2.167) seizures throughout the night of June 7. CMH Records, E12.88. Yohan's persistent seizures were defined as "status epilecticus," a condition that can cause a finding of "restricted diffusion" on brain imaging. R2.167, 298, R3.14. To manage the seizures, he was given a sedative requiring intubation. E12.88; R2.169.

On June 7, Dr. Marc Wainwright, attending child neurologist at CMH, consulted on Yohan's seizures. R2.114. Dr. Wainwright's physical exam, which included tapping Yohan's knee joints with a hammer, found no external injuries, no injuries to his neck, normal movement to his arms and legs, and was largely normal in every other respect. R2.165, 167-68, 226; CMH Records, E8.177. Dr. Wainwright identified potential causes for the intracranial bleeding as infection, inflicted "trauma," coagulopathy, metabolic disorder, or birth trauma, which he documented in his consult note can still present 3-5 weeks after delivery. E8.177. The term "trauma" means anything could be described as a "force"—whether accidental or non-accidental. R7.249. During his treatment of Yohan, Dr. Wainwright did not evaluate for the potential existence of congenital abnormalities, such as BEH. R2.177-78; *see* Glossary, A.12.

Yohan had two in-patient ophthalmological examinations, June 7 and June 14, involving both an external exam and a dilated fundus exam. R6.223, R7.45-50; CMH Records, E8.173-74, E8.69; *see* Glossary, A.13. The June 7 dilated exam revealed scattered retinal hemorrhages in both eyes, right greater than left, and one small, subhyaloid (*i.e.*, pre-retinal, R6.226; R7.44-45) hemorrhage to the right eye. E8.174. No

other abnormalities were noted, R6.227, and Yohan had normal retinal functioning. E8.174; R7.46.

On June 14, resident Dr. Grace Wu examined Yohan and found the retina to be flat and attached, with scattered retinal hemorrhages bilaterally, and one small pre-retinal hematoma to the right eye. E8.69; R7.45-46. Dr. Wu again noted that the hemorrhages were greater in the right eye than the left eye. E8.69. Supervising attending physician Dr. Yoon examined Yohan immediately following Dr. Wu noted bilateral, multi-layer, too-many-to-count retinal hemorrhages, *left greater than right*, "[l]ikely unchanged from previous exam." *Id.* Yohan had neither of the two retinal injuries often associated with abuse: retinoschesis and macular folds. R7.69-70.

The 2007 guidelines from the American Academy of Pediatrics ("AAP") for the evaluation of suspected child abuse directs that the ophthalmologist provide documentation of the alleged retinal hemorrhages by either photography or detailed annotated drawings. R7.51-53. The CMH records do not contain any photographs or annotated drawings from the June 7 examination of Yohan's retinas, R7.51, and neither Dr. Yoon nor Dr. Wu photographed or made annotated drawings of their observations, R7.50-52.

On June 8, CMH obtained scans of Yohan's skeletal system, CMH Radiology Reports, E12.131. The survey was very limited and many of the images were suboptimal. E12.132. The CMH radiological report, authored by Dr. Jennifer Nicholas, noted an irregularity along the lateral (outer, R5.147), distal (lower end, R5.137) left femoral metaphysis (knee area). E12.131. Dr. Nicholas's June 8 report also noted concern for fracture in three of Yohan's left ribs, E12.131, but later exams showed that there were never any rib fractures. E14.44

Isolated x-rays of Yohan's left knee from June 8 and June 10 noted an abnormality along the outer side of Yohan's distal femoral metaphysis, which one CMH radiologist noted "may represent a corner fracture." CMH Radiology Reports, E12.125, 131. The possible fracture did not make sense to Teresa and K.S, R9.177; from the time of Yohan's birth, they had constantly manipulated his left leg through diaper changes, massages, clothing, and nursing, and never had Yohan given any signs of pain or distress. R9.177-78, R10.151-52. The cast application took about ten minutes, for which Yohan was awake and did not exhibit any signs of pain or discomfort while the doctor manipulated his left leg. R9.170, R10.202. Once the cast was on, Yohan immediately began kicking his left leg, causing the cast to slip from mid-thigh to below his knee. R9.187, R10.204.

On June 8, Yohan was weaned off the sedative. E8.106, 148; R2.168. On June 9, Yohan was extubated and began nursing without incident, cooing, and smiling, R10.215—a recovery that Dr. Wainwright found to be very promising. E8.103, 148; R2.169. Also on June 9, CMH performed a second in-patient MRI study. CMH Radiology Reports, E12.127. The June 9 CMH report noted that the restricted diffusion was more extensive than on June 6 and noted the small, posterior subdural collections and the left-side subarachnoid hemorrhage identified on previous scans. *Id.* It also noted the new identification of two small subarachnoid hemorrhages in the right frontal region as well as a small amount of intraventricular hemorrhage. E12.127-28.

Yohan was discharged from CMH on June 15 at approximately 3:30 p.m. to the care of Teresa's sister. R10.216. Due to DCFS involvement, Teresa G. and K.S. were not permitted to have any unsupervised contact with their children, R2.77. To minimize the disruption to Yohan and Marika, the Parents moved in with Tobey Benas, a neighbor in

the same building, R6.142, while alternative caregivers stayed with the children in the family residence. R2.93.

D. Post-Discharge and the Filing of the Petitions Below.

On June 17, Yohan had an entirely normal follow-up appointment with Dr. Chandra-Puri. R6.92-93. When Dr. Chandra-Puri palpated Yohan's legs, he did not exhibit any signs of pain or distress. R6.94. On June 20, Investigator Bono met again with the family. R2.80. During all of their meetings with investigators, the Parents tried to figure out what had happened to Yohan, offering potential explanations such as Marika interacting too roughly with him and baby equipment the family used. R2.80-81, 88-92. Throughout the investigation, Investigator Bono observed K.S. and Teresa with the children weekly, noting the interactions to be positive and loving. R2.100-01.

On June 23, Yohan received follow-up x-ray imaging of his skeletal system. CMH Radiology Reports, E12.123; R3.45. By this point, Yohan had kicked his left leg cast down below his knee. R9.188-92, R10.207, 218-19; Parents' Group Exh. 33 (photos of Yohan's leg and cast). When the cast was removed for x-rays, Dr. Fortin noted Yohan to be "moving his left lower extremity actively." CMH Records, E11.220. Dr. Jennifer Nicholas reported "periosteal reaction" on the distal femoral metaphysis, which she interpreted as being consistent with a healing fracture. E12.123.

On June 27, Investigator Bono again met with Teresa G. at the family home, at which time Teresa shared some of the complications from Yohan's birth. R2.81. During this meeting, Teresa tearfully stated that because the Parents knew that Yohan's findings were not due to abuse, they wanted to obtain another medical opinion so as to provide answers for Yohan's medical conditions. R2.94-95, R9.192, R10.220. Based upon the

DCFS investigation, on July 25, 2013, the State filed Petitions for Adjudication of Wardship as to Yohan and Marika K. C1.2-3, C9.269.

Through their search for answers, Teresa and K.S. learned about the risks of vitamin D deficiency, R9.194, R10.221, 223, which is the primary cause of rickets and can predispose individuals to venous thrombosis (i.e., clotting in the veins). R4.85, R5.183; E13.7 (Barnes Report); *see* Glossary, A.14. CMH had never tested Yohan's vitamin D levels, R4.188-91, R6.183, 197, but July 2011 blood tests showed Teresa to have an "insufficient" level and Yohan to have a "deficient" level. R6.102; Parents' Exh. 19, E14.28-32, E14.23-24 (Sullivan Report).

On October 12, 2011, Yohan received a follow-up MRI at CMH, which noted that "[t]he extra-axial CSF spaces appear prominent," CMH Radiology Reports, E12.122, a description that refers to the condition benign external hydrocephalus. R5.190, R8.50. BEH is a condition of enlarged spaces between the brain and the arachnoid membrane—called the subarachnoid space, which is filled with cerebral spinal fluid ("CSF"). R8.8-9; *see* Glossary, A.12. The enlarged subarachnoid space causes increased stretching to the intracranial veins, which predisposes children with BEH to bleeds from minor or trivial force (*i.e.*, the minor impacts from everyday life, R5.159), or from medical conditions such as venous thrombosis. R5.120, R8.10-12; R2.150.

In November of 2011, the Chief of Pediatric Neuroradiology at Stanford University Medical Center, E13.138 (Barnes CV), Dr. Patrick Barnes, became involved in Yohan's case. R5.60. Dr. Barnes, who is also a pediatric radiologist, reviewed all of Yohan's imaging studies in chronological order and concluded that Yohan had pre-existing BEH predisposing him to intracranial bleeding triggered by ordinary trivial trauma, medical conditions such as venous thrombosis, or spontaneously. R5.66; Parents' Exh. 13, Barnes

Report, E14.7-13. On Yohan's skeletal images, Dr. Barnes visualized the irregularities to Yohan's distal femur but did not identify them as either a fracture or the periosteal reaction of a healing fracture. E14.9-10. Rather, Dr. Barnes observed many findings congenital rickets. E14.12; *see* Glossary, A.12.

In the fall of 2011, Dr. Christopher Sullivan, Director of Pediatric Orthopedics at the University of Chicago, E14.12 (Sullivan CV), consulted on Yohan's case. R6.11. Dr. Sullivan, who has diagnosed at least 1,000 femur fractures throughout his career, reviewed all of Yohan's bone imaging and medical records and concluded that Yohan's knee irregularities were not diagnostic for a fracture, that on June 23 there was an absence of periosteal reaction to Yohan's left femur indicative of a healing fracture, and that the edge irregularities at the growth areas of Yohan's left leg were consistent with rickets. Parents' Exh. 15, Sullivan Report, E14.22-24. These radiographic findings, combined with the absence of pain or tenderness plus low vitamin D levels, led Dr. Sullivan to conclude that Yohan most likely never had a fracture to his left distal femur. E14.24.

In December of 2011, pediatric neurosurgeon Dr. David M. Frim, the Chief of Neurosurgery at the U. of C., E14.61 (Frim CV), provided a neurosurgical assessment of Yohan. *See* Parents' Exh. 27, Frim Report, E14.111-12. After reviewing Yohan's brain images and medical records, Dr. Frim concluded that Yohan was born with BEH, that he likely sustained a hemorrhage during birth that then caused him to be even more susceptible to additional hemorrhages, and these hemorrhages then caused the seizures he had upon admission at CMH on June 6, 2011. R8.13-14; E14.111-12. Dr. Frim also explained that blood from the subarachnoid space surrounding the brain can travel to the retinas, causing retinal hemorrhaging. *Id.* On February 2, 2012, Yohan had an in-person appointment with Dr. Frim, at which time Dr. Frim observed Yohan to be progressing

quite well (Yohan began walking at nine months and babbling at ten months, R9.197), even exhibiting development advanced for his age group. *See* Parents' Exh. 29, Frim Clinical Note, E14.113-15; R8.75.

E. Evidence and Ruling At the Adjudicatory Hearing

Medical Expert Testifying to Inflicted Causation

Kristine Fortin, M.D., M.P.H. In support of its petition, the State called Dr. Kristine Fortin as a witness. R3.233. Dr. Fortin, who practices as a pediatrician on the child protective services team at CMH, R3.240, received her medical degree from University of Montreal (2002) as well as a Master's in public health from Brown University (2009). R3.235-36; *see also* State's Exh. 9, Fortin CV, E12.221-25. Dr. Fortin was board certified in General Pediatrics in 2006 and in Child Abuse Pediatrics in the fall of 2011. R3.234. She is a clinical instructor at Northwestern Medical School and has three peer-reviewed publications, R3.239, none of which address the topics of BEH, retinal hemorrhages, rickets, or fractures, R4.129-30. The trial court qualified Dr. Fortin as an expert in pediatrics and, over Parents' objection, in child abuse pediatrics. R4.8. In addition to the facts from the GAL's opening brief, GAL Br. 4-10, Parents include the following:

Dr. Fortin served as a consultant on Yohan's case. R4.9, 98. In a June 27, 2011 report, she opined about the potential causation of Yohan's intracranial bleeding, retinal hemorrhages, and presumed femur fracture. State's Exh. 7, Fortin 2011 Report, E12.178-87. This report did not mention either BEH or rickets, and it was Dr. Fortin's "best medical opinion that the injuries . . . are explained by inflicted trauma." *Id.* On March 15, 2012, after reviewing the reports issued by Dr. Barnes, Dr. Sullivan, and Dr. Frim, Dr. Fortin issued an addendum responding to their opinions, concluding: "My best medical

opinion remains that the constellation of findings is explained by inflicted trauma." State's Exh. 8, Fortin 2012 Addendum, E12.213-20.

Dr. Fortin testified that tests were conducted to rule out medical causes for Yohan's intracranial bleeding, but did not articulate what specific medical causes were considered and excluded. R4.37. She testified that the types of force that "could" cause subdural hematomas include an impact force or an acceleration/deceleration force. R4.34. With respect to the fracture that had been diagnosed by CMH physicians, Dr. Fortin testified that a metaphyseal fracture "could" be caused by a sheering force (forces in opposite directions) or a traction force (a pulling force). R4.50-51. Based on her review of the CMH lab data, she claimed there was no medical cause predisposing Yohan to fractures—though she did not identify the specific medical conditions the testing was intended to detect—and it was her opinion that Yohan's fracture was caused by inflicted trauma. R4.54. As to the retinal hemorrhages, Dr. Fortin opined that there was no medical cause, but did not identify what specific medical causes were considered. R4.57-58. In her opinion, the mechanism for the retinal hemorrhages was acceleration/deceleration forces. R4.58. However, Dr. Fortin also stated that she was not offering an opinion as to the mechanism of Yohan's intracranial bleeding, retinal hemorrhages, or fracture. R4.204-06.

Dr. Fortin testified that birth trauma was considered as a potential cause for the intracranial bleeding, but opined that birth trauma could not account for the presumed fracture, R4.61, and was unlikely to account for the retinal hemorrhages based on Yohan's age, R4.64-65, leading her to rule out birth trauma as an explanation for the "constellation" of injuries. R4.66, 163. Dr. Fortin was not familiar with any literature looking at birth trauma in the context of BEH, R4.167, and none of the literature she relied upon for her understanding of retinal hemorrhages from birth included infants with BEH, R4.174.

Dr. Fortin did not dispute the BEH diagnosis as to Yohan, R4.159, and stated that she would not feel qualified to override the opinion of a neurosurgeon with respect to a neurosurgical injury. R4.128. Despite her lack of expertise, Dr. Fortin rejected BEH as a cause for Yohan's intracranial bleeding because, in her opinion, BEH could not account for the retinal hemorrhages or the fracture. R4.76-77. In any case in which she provides consultation, the only information Dr. Fortin has regarding retinal hemorrhages comes from the description provided by the ophthalmologist, and in Yohan's case she relied on Dr. Yoon's description. R4.118, 120, 180. Dr. Fortin agreed that the AAP 2007 guidelines for evaluation of child abuse direct that fundoscopic findings be documented via photographs or annotated drawings, and that neither method was done in Yohan's case. R4.170-71. In her March 15, 2012, addendum, Dr. Fortin did not review the journal article Dr. Frim had referenced in his December 2011 report, which article by Dr. Joseph Piatt profiled an infant who had sustained extensive, multi-layer retinal hemorrhages secondary to BEH. R4.177-80; *see infra* pp. 21-22, 32 for additional references to Piatt article.

Dr. Fortin stated that the type of fracture she believed Yohan had sustained can be completely asymptomatic. R4.78-79; *but see infra* pp. 26, 39. She also opined that a metaphyseal fracture can heal with little or no periosteal reaction, *but see infra* pp. 26, 39, a proposition she attributed to Dr. Paul Kleinman's textbook *Diagnostic Imaging of Child Abuse*, which textbook includes two chapter authored by Dr. Patrick Barnes. R4.83-84, R5.30-31; Fortin 2012 Addendum, E12.218. On direct examination, Dr. Fortin claimed she could definitively diagnose Yohan with a left femur fracture, R4.93, but she later testified that her identification of the periosteal reaction was based on her review with the radiologist, R4.96, and she relied on the CMH orthopedist and radiologist for diagnosis of the fracture, R4.118.

Dr. Fortin offered that the most common cause of rickets is a vitamin D deficiency. R4.85. Dr. Fortin relied upon the radiographic reports by CMH radiologists for the conclusion that Yohan's bone images had no signs of rickets. R4.88. As for laboratory indicators of rickets additional to vitamin D deficiency, Dr. Fortin agreed that the AAP 2007 guidelines for evaluation of child abuse recommend measuring calcium, alkaline phosphatase, and parathyroid hormone. R4.194-96. Yohan's serum calcium was flagged low, his alkaline phosphatase measured 311 on a range of 35 to 350, and CMH never conducted a measurement of Yohan's parathyroid hormone. R4.194-96. Dr. Fortin had never consulted on a case at CMH involving a child with rickets, R4.87, but agreed that CMH did not conduct the full comprehensive metabolic work-up outlined in the AAP guidelines. R4.189, R5.8.

Medical Experts Conflicted or Neutral as to Causation

Marc Wainwright, M.D., Ph.D. Dr. Wainwright, the CMH attending pediatric neurologist for Yohan during his hospitalization, testified as a witness for the State; he was board certified in Neurology, with Special Qualification in Child Neurology, in the fall of 2010, R2.157, and has served as an attending neurologist at CMH since 2005. R2.106; *see also* State's Exh. 4, Wainwright CV, E12.153-68. Dr. Wainwright received his medical degree and doctoral degree in Neuropharmacology from the U. of C. R2.106-07. Dr. Wainwright is an Associate Professor at Northwestern University School of Medicine, and has published articles the topics of sepsis, mechanisms of brain injury, stroke, and a single article about neuroimaging in cases of child abuse. R2.108. In addition to the facts from the GAL's brief, GAL Br. 10-11, Parents include the following:

The trial court qualified Dr. Wainwright as an expert witness in the field of child neurology. R2.113. Dr. Wainwright diagnosed Yohan as having had subdural hematomas,

subarachnoid hemorrhaging, and ischemia (based on the presence of restricted diffusion) in June of 2011. R2.141. In addition to diagnosing the existence of those conditions, Dr. Wainwright also rendered his opinions as to the cause of the Yohan's seizures and abnormal brain imaging. On direct examination, Dr. Wainwright gave his opinion that the most likely explanation for the intracranial findings was external inflicted trauma. R2.141. Dr. Wainwright did not distinguish between accidental and non-accidental inflicted trauma. R2.177. Dr. Wainwright's opinion on inflicted trauma was predicated on his assumption that Yohan's had a femur fracture, R2.143, 149-50, acknowledging that if Yohan did not, in fact, have a fracture, Dr. Wainwright would reevaluate his opinion. R2.201. Dr. Wainwright did not know the mechanism that caused the inflicted trauma he was alleging, R2.216, and said that to identify an exact cause would be "speculation." R2.238-39.

Dr. Wainwright claimed in his initial testimony on direct exam that birth trauma was an unlikely explanation for Yohan's intracranial bleeding because it could not account for the alleged femur fracture or the retinal hemorrhages. R2.143. Dr. Wainwright was permitted to testify as to these other conditions over Parents' objection that he was not an expert in either orthopedics or ophthalmology. R2.114, 160.

Dr. Wainwright testified that the prevalence of subdural hematoma in infants born through a precipitous delivery, such as was the case with Yohan, is as high as 25 percent. R2.179. He also testified that Yohan's intracranial bleeding was not too old to be caused from birth trauma, which can be found in healthy babies up to five weeks old. R2.180, 185. The literature Dr. Wainwright relied upon to identify the age range for manifestation of birth trauma did not include infants with BEH. R2.180. The witness acknowledged that the posterior location of Yohan's bleeds were atypical for inflicted, non-accidental trauma but consistent with bleeds found in babies who have sustained birth trauma. R2.183-84. On

cross, Dr. Wainwright changed his testimony about retinal hemorrhages and agreed that they *can* be caused by birth trauma. R2.186. Dr. Wainwright testified that he could not definitively rule out birth trauma as a cause of Yohan's intracranial bleeding. R2.145.

Dr. Wainwright never considered the presence of BEH during Yohan's hospitalization, and according to Dr. Wainwright, no doctor at CMH considered it. R2.177-78. In the seven years Dr. Wainwright has practiced in the ICU, he has never seen a case of BEH diagnosed, R2.156, and in his entire career he has seen only two patients with BEH, R2.208. Nonetheless, at trial Dr. Wainwright offered his opinion that Yohan did not have BEH because his head circumference was not abnormal, because he had seizures, and because he did not believe BEH could account for the retinal hemorrhages or alleged femur fracture. R2.150.

Dr. Wainwright acknowledged that the BEH literature does not consider other alleged injuries as relevant to whether or not a child has BEH. R2.152. Dr. Wainwright agreed that BEH causes an infant to be more susceptible to intracranial bleeding from incidental or minor trauma, R2.150, 242, and also agreed that in the presence of BEH, it is possible for subdural hematomas to occur spontaneously, or to re-hemorrhage spontaneously. R2.205, R3.27. Under cross-examination, Dr. Wainwright changed his prior testimony and agreed that retinal hemorrhages *can* be a result of increased intracranial pressure caused by subdural or subarachnoid hemorrhages, or can be an outgrowth of subarachnoid hemorrhages directly, R2.190-91, and that there is at least one documented case study of an infant with BEH, profiled in the peer-reviewed article by Dr. Joseph Piatt, who had retinal hemorrhages similar to Yohan's that occurred in the absence of inflicted trauma, R3.21, 25-26.

Based on his own treatment of Yohan while in the hospital as well as his review of all of Yohan's medical records, Dr. Wainwright agreed that Yohan's outcome has been excellent. R2.246-47. Furthermore, because the prognosis for children who are victims of child abuse can be very dire—with a 15 percent incidence of death and a 50 percent incidence of neurological deficits, per the witness—Dr. Wainwright agreed that Yohan's excellent outcome might be evidence of absence of serious trauma. R2.247-49.

Hawke Yoon, M.D. Dr. Hawke Yoon is an attending pediatric ophthalmologist at CMH. R6.213; *see also* State's Exh. 11, Yoon CV, E13.61-66. Board certified in ophthalmology in fall of 2010, R7.37, Dr. Yoon has been with CMH's Department of Ophthalmology since 2007 and serves as a clinical instructor at Feinberg School of Medicine. E13.61. He has no published articles or research. R7.39. The trial court qualified Dr. Yoon as an expert in pediatric ophthalmology. R6.218. In addition to the facts from the GAL's opening brief, GAL Br. 13, Parents include the following:

Dr. Yoon first saw Yohan on June 14, 2011, and he was the only CMH ophthalmologist to claim that the hemorrhaging in Yohan's left eye was greater than in the right eye. R6.220; CMH Records, E8.69-70, 174. During his testimony, Dr. Yoon identified drawings showing retinal hemorrhages in the presence of BEH (*see* Parents' Exh. 23, Article by Piatt, Joseph H., E14.37-44 (used for demonstrative purposes)) and testified that the hemorrhages in the drawings were similar to those seen in Yohan during his fundoscopic exam. R7.86, 103-04, 113-14. He could not describe any differences. R7.126. Dr. Yoon admitted that he did not follow the 2007 AAP guidelines by failing to document his findings through photographs or annotated drawings. R7.54.

During his trial testimony on May 31, 2012, Dr. Yoon attempted to proffer an opinion as to the causation of Yohan's retinal hemorrhaging. *See, e.g.*, R6.237. However,

the trial court disallowed and struck this testimony as Dr. Yoon had explicitly testified at his deposition one month prior that he did not at that time, and would not in the future, have any opinion as to the cause of Yohan's retinal hemorrhages. R6.248-R7.2; *see also* C2.124-27 (relevant portions of May 1, 2012, discovery deposition transcript).

On direct examination, over objection of Parents due to the witness's inconsistent deposition testimony, R6.88, R7.111-13, 117, Dr. Yoon was allowed to testify as to potential causative factors he ruled out and his general opinions about causation of retinal hemorrhages. Despite the ruling not allowing him to testify as to the causation of Yohan's retinal hemorrhaging, Dr. Yoon averred that birth trauma was an unlikely explanation because birth-related retinal bleeding generally resolves by two-to-four weeks. R7.15-16. Though Dr. Yoon testified that the two-to-four-week resolution time would also apply in cases of precipitous birth, at his May 1st deposition he testified that he did not know how long it would take for retinal hemorrhages stemming from traumatic, precipitous, or abnormal deliveries to resolve. R7.85-86. Dr. Yoon also knew nothing about how long it would take for birth-related retinal hemorrhages to resolve in a baby with BEH. R7.84.

Over objection by Parents that it contradicted his deposition testimony of having no opinion about the causation of Yohan's retinal hemorrhages and that it was beyond his expertise, R7.129-30, Dr. Yoon still was permitted to claim that he ruled out intracranial hemorrhage and/or intracranial pressure as causes for Yohan's retinal hemorrhages. Though not disagreeing that retinal hemorrhages can occur secondary to intracranial hemorrhages, R7.77, 88, he claimed that the type, number, and location of those of retinal hemorrhages would be different. R7.16-17, R7.131. The witness did not distinguish between intracranial hemorrhage and intracranial pressure. *See, e.g.*, R7.16, lines 4-7 and lines 16-19; R7.130, lines 12-15; R7.131; lines 18-21. On cross, Dr. Yoon agreed that he

has no expertise in intracranial bleeding or intracranial pressure. R7.38. Though claiming he had ruled out medical causes for the retinal hemorrhaging, R7.18, 20, Dr. Yoon acknowledged did not know exactly what BEH was, and he did not know specifically what impact BEH could have on retinal bleeding. R7.39-41.

Delilah Burrowes, M.D. Testifying as a witness for the GAL was Dr. Delilah Burrowes, a neuroradiologist at CMH. R8.101. Dr. Burrowes received her medical degree from Meharry Medical College and is board certified in Radiology (1996) with Added Qualifications in Neuroradiology (1997). R8.103-03; *see also* GAL's Exh. 3, Burrowes CV, E13.75-85. Dr. Burrowes serves as Division Head of CMH's Neuroradiology Section, a team of five neuroradiologists, and is an assistant professor at Northwestern University School of Medicine. R8.105; E13.77. Though Dr. Burrowes completed a one-year fellowship in pediatric neuroradiology in 1998, R8.103, 109, a significant portion of her experience in neuroradiology has been with adults. R8.110. The court qualified Dr. Burrowes as an expert in neuroradiology, with no objection, as well as pediatric neuroradiology over Parents' objection that the majority of the witness's practice has been with adults. R8.110. In addition to the facts from the GAL's opening brief, GAL Br. 11-12, Parents include the following:

The June 6 MRI is the only imaging sequence for Yohan that Dr. Burrowes reviewed. R8.173. On this limited imaging, she did not see any signs of venous thrombosis in the sinus veins. R8.128, 130. Dr. Burrowes had no opinion as to whether there was cortical venous thrombosis as CMH never evaluated for it. R8.169.

Dr. Burrowes understands BEH to be a prominence of the subarachnoid space. R8.13-36. Though she measured Yohan's subarachnoid space on June 6 to be as much as seven millimeters in some areas, R8.153, Dr. Burrowes does not render a diagnosis of

BEH for any subarachnoid space less than ten millimeters. R8.164. Dr. Burrowes has worked with Dr. Frim, consulting with him about brain imaging studies. R8.156-58. Dr. Burrowes agreed that Dr. Frim possesses the ability to read imaging studies, and she knows Dr. Frim is a well-respected neurosurgeon. R8.157, 159. She also knows Dr. Frim has expertise in the area of BEH and is aware of some of his published work on the subject. R8.159-60, 162. Dr. Burrowes is also familiar with Dr. Barnes' work, has read some of it, and knows he is a well-respected neuroradiologist. R8.182.

Joseph Janicki, M.D. Dr. Joseph Janicki, pediatric orthopedic surgeon affiliated with CMH, testified on behalf of the State. R3.32; *see also* State's Exh. 5, Janicki CV, E12.169-72. Dr. Janicki attended medical school at Case Western Reserve University and received board certification in Orthopedic Surgery in 2009. R3.33-34. Dr. Janicki has published articles on topics such as clubfoot preservation, scoliosis, and the spine. R3.36. Dr. Janicki serves as an Assistant Professor of Orthopedic Surgery at Northwestern University. R3.38. The trial court qualified Dr. Janicki as an expert in pediatric orthopedics. R3.39. In addition to the facts from the GAL's opening brief, GAL Br. 11-12, Parents include the following:

Dr. Janicki never saw Yohan in the hospital, R3.111, and at the time that Yohan presented for follow-up with Dr. Janicki on June 24, his diagnosis was of a possible fracture. R3.44, 46. On June 23, Yohan had received a follow-up skeletal survey and isolated x-ray of his knee. R3.54. Dr. Janicki was unable to recall whether he personally conducted Yohan's examination on June 24, R3.114, and was unable to recall whether he viewed Yohan's x-rays prior to the appointment, R3.44.

Dr. Janicki observed no periosteal reaction on the June 8 images, R3.53, and explained that if it was a fracture there would be subsequent signs of healing. R3.49. In the

June 23 x-rays, Dr. Janicki was specifically looking for signs of a healing fracture. R3.54. Prior to forming his opinion as to whether Yohan had a fracture, Dr. Janicki was aware that Yohan had originally presented to CMH with seizures, intracranial bleeding, and retinal hemorrhaging. R3.62-63, 171. He agreed that this information may have influenced his diagnosis. R3.172. Despite agreeing that periosteal reaction can be seen in rapidly growing infants, R3.116, he concluded that the presence of reaction in Yohan meant that he had sustained a fracture to his distal left femur on June 6, 7, or 8. R3.59-60.

Dr. Janicki was unable to offer any opinion as to how Yohan's alleged fracture had occurred. R3.125-26, 128. Dr. Janicki agreed that there is an expectation a baby would exhibit pain when sustaining a fracture and thereafter. R3.116-17, 121. Although he stated that Yohan would have been able to move his left knee by June 23 without signs of pain, R3.71, Dr. Janicki then stated that concern about pain to the fracture site prevented him from conducting a full range of motion exam on June 24. R3.77. Dr. Janicki confirmed that if during hospitalization Yohan was moving his extremities freely and without pain while awake, that would be inconsistent with the alleged fracture. R3.120, 123-24.

Dr. Janicki has never diagnosed a patient as having rickets, R3.82, and the single patient he could recall with rickets within the past six months was a nine-year-old child, R3.83-84. Dr. Janicki explained classic rachitic (*i.e.*, rickets) changes generally involve the head and ribs, R3.90, but that he had no expertise involving the head or ribs, and he could not disagree with any finding of rachitic findings as to Yohan's cranium or ribs. R3.153. Dr. Janicki stated at least six times that he does not have expertise in the area of rickets. R3.80, 90, 99, 109, 136, 156. He was unable to state the principal cause of rickets, R3.137, he has no formal training in rickets. R3.138, and he had never heard of congenital rickets, R3.177.

Jennifer Nicholas, M.D. The GAL called Dr. Jennifer Nicholas as a witness. R7.155. Dr. Nicholas, who practices at CMH, was board certified in Diagnostic Radiology (2009) with a Certificate of Added Qualification in Pediatric Radiology (fall of 2011). R7.155-57; *see also* GAL's Exh. 2, Nicholas CV, E13.70-74. Dr. Nicholas is an Assistant Professor of Radiology at Northwestern Medical School, E13.71, and has a single publication, which examined the issue of breast masses, R7.185. The trial court qualified Dr. Nicholas as an expert in radiology and pediatric radiology. R7.160. In addition to the facts from the GAL's opening brief, GAL Br. 13-14, Parents include the following:

The only full skeletal survey that Dr. Nicholas reviewed was from June 8, R7.162, 204, which was a limited study and produced sub-optimal images. R7.210-11; CMH Radiology Reports, E12.131-32. Prior to her reading of the June 8 images, Dr. Nicholas was aware that Yohan had a head injury. R7.188. In addition to the irregularity on Yohan's left femur, Dr. Nicholas noted irregularities in Yohan's left ribs that she thought were suspicious for a fracture. R7.189-90. Yohan had no rib fractures. R7.190.

Dr. Nicholas testified to observing some periosteal reaction in her reading of the June 23 x-ray of Yohan's left knee, but agreed that periosteal reaction can occur for multiple reasons including rapid growth and rickets. R7.214-15. She also noted irregularity in the upper portion of Yohan's tibia. R7.176; CMH Radiology Reports, E12.123. Dr. Nicholas testified that rickets can involve the metaphysis of a long bone, often having a cupping or fraying appearance, R7.170, and she agreed that an early location for rickets to appear is the distal femur and proximal tibia. R7.189. Dr. Nicholas did not interpret any of the studies from the June 23 skeletal survey. R7.204.

Dr. Nicholas has no expertise in congenital rickets or in diagnosing rickets in infants under six months old. R7.194. She knows Dr. Barnes, respects his opinions, knows

that congenital rickets is an area of interest for him, and she has read some of his peer-reviewed articles on the subject, though not within the year preceding June 2011. R7.196-98, 205. Though Dr. Nicholas claimed seeing no signs of rickets in Yohan's June 8 skeletal survey, she was unable to say whether Yohan had rickets and agreed that the sub-quality of the June 8 images hindered her evaluation. R7.210-11.

Astrid Kyle Mack, M.D. Dr. Astrid Kyle Mack, a witness called by the GAL, is a pediatric hematologist at CMH and is board certified in both Pediatrics (2005) and Pediatric Hematology/Oncology (2009), R6.154-56; *see also* GAL's Exh. 1, Mack CV, E13.67-70. The trial court qualified Dr. Mack as an expert in pediatrics and pediatric hematology. R6.162. In addition to the facts from the GAL's opening brief, GAL Br. 12-13, Parents include the following:

Dr. Mack was not asked to do any testing for clotting disorders, which is its own separate category of testing, and his consultation was limited to assessing for bleeding disorders. R6.184-85. Dr. Mack did not conduct a vitamin D test nor did he recommend a thrombophilia work-up, though an infant does not need to have a clotting disorder in order to develop venous thrombosis. R6.183, 187; CMH Records, E8.162.

Anita Chandra-Puri, M.D. Testifying on behalf of the Parents was Dr. Anita Chandra-Puri, who is the primary care pediatrician for Marika and Yohan, was board certified in General Pediatrics in 1998 (re-certified 2005), and is a clinical instructor at Northwestern Medical School. R6.66-67; *see also* Parents' Exh. 17, Chandra-Puri CV, E14.26-27. The trial court qualified Dr. Chandra-Puri as an expert in general pediatrics. R6.69. On the second or third day of Yohan's hospitalization, the doctor visited the family in the ICU to offer support during Yohan's illness; the Parents were tearful in that visit. R6.89. It was Dr. Chandra-Puri's opinion that the Parents' behavior and concern as to their

children was completely appropriate at all times and she has never had a question of improper care or neglect. R6.84, 107-08.

Medical Experts Testifying to Medical Conditions and/or Absence of Injury

David Frim, M.D., Ph.D. The Parents called Dr. David Frim, who had been treating Yohan as his patient since February, 2012, R8.74, and who received no monetary compensation for his testimony in this case, R8.77. Dr. Frim is a neurosurgeon and pediatric neurosurgeon at the U. of C., board certified by both the American Board of Neurologic Surgeons (1998) (served as invited oral examiner May 2012, R7.235) and the American Board of Pediatric Neurological Surgery (1999, recertified 2009). R7.222, 230; *see also* Parents' Exh. 26, Frim Curriculum Vitae, E14.61-110. As Chief of Neurosurgery at the U. of C., Dr. Frim supervises all neurosurgical care provided at the hospital, directing the work eleven neurosurgeons. R7.222-23. When Dr. Frim first began practicing at U. of C. in 1996, he served as the Chief of Pediatric Neurosurgery. R7.229-30.

Dr. Frim sees between 1,000-1,500 patients yearly, R8.6-7, and conducts approximately 300-400 pediatric neurosurgeries each year, including on patients less than six months old, addressing medical issues that can include trauma to the brain and spine, R7.247-48. At the U. of C., Dr. Frim works closely with, and considers himself to be a member of, the hospital's child protection team service. R7.249-R8.2, R10.26. Many entities have formally recognized Dr. Frim as a preeminent physician in his field, both in the Chicago area and nationwide. R7.231-32; E14.65-66.

Dr. Frim graduated from Harvard University with both a medical degree and a doctorate in Neuroscience. R7.228. Dr. Frim serves as a full Professor of Surgery at the U. of C. Medical School, a position that requires an international reputation in his field as well as the generation of original knowledge. R7.223-24. Dr. Frim's endowed chair provides

support for his ongoing lab research of congenital anomalies of the nervous system, including BEH. R7.225. His areas of research and clinical expertise include studying the mechanisms of potential brain injuries. R7.235-36. Dr. Frim has published over 100 peer-reviewed articles and has served as the Editor-in-Chief of *Pediatric Neurosurgery*, a peer-reviewed medical journal, since 2004. R7.226, 233-34; E14.68.

In 2000, Dr. Frim and one of his students published a peer-reviewed article in *Pediatric Neurosurgery*, "A Theoretical Model of Benign External Hydrocephalus that Predicts a Predisposition Towards Extra-Axial Hemorrhage After Minor Head Trauma." R7.238; *see also* Parents' Exh. 24, Article by Papasian and Frim, E14.45-50 (admitted for limited purpose of expert qualification, R7.239). This paper describes a mathematical model of BEH that predicts children who are predisposed a predisposition to bleeds outside of the brain after minor or trivial trauma. R7.238. In 2005, Dr. Frim and a colleague co-authored a textbook chapter entitled "Extracerebral Fluid Collections in Infants," which examined conditions such as BEH. R7.240; *see also* Parents' Exh. 25, Chapter by Frim and Curry, E14.51-60 (admitted for limited purpose of expert qualification, R7.239). This chapter was published in *Principles and Practices of Pediatric Neurosurgery*, a medical reference textbook utilized by physicians in the field of neurosurgery. R7.241, R10.47. The trial court qualified Dr. Frim as an expert in the fields of neurosurgery and pediatric neurosurgery. R8.6.

During Dr. Frim's testimony, he created a schematic drawing demonstrating the relational location of the dural membrane, arachnoid membrane, subarachnoid space (which in normal children does not exceed three millimeters, R8.21), and the brain. R8.19-20; *see* Parents' Exh. 28, Frim Diagram, E14.122-23 (used for demonstrative purposes, R8.34). This diagram also demonstrated the general location of a subdural hematoma and

the impact that a collection of blood in the subdural space can have on the other cranial components. R8.23-26. Specifically, when there is a collection of blood in the subdural space—a space that under normal circumstances should not exist because the dural and arachnoid membranes adhere to one another, R8.24—that collection will further widen the space between the brain and the skull bone, thereby acting as an additive to BEH and forcing the veins to stretch an even greater distance. R8.26, 31.

With the diagram, Dr. Frim also demonstrated how the arachnoid membrane and subarachnoid space connect to other systems that are connected to the brain, such as the retina of the eye. R8.27. Normally, the arachnoid membrane will be positioned very closely to the optic nerve and the retina, but in a child with BEH, the same conditions that cause the subarachnoid space surrounding the brain to be enlarged will also cause enlargement of the subarachnoid space around the optic nerve and retina. R8.27. Therefore, if blood from an injured vein enters the subarachnoid space, as it did with Yohan, the blood can then travel within the subarachnoid space and find itself in the subarachnoid space of the retina, where it would then be viewed as retinal hemorrhages. R8.28-29, 33.

Dr. Frim diagnosed Yohan as having on June 6, 2012, an older subdural hematoma as well as some acute (*i.e.*, new) subdural blood. R8.16, 25-26. These old and new bleeds most likely caused Yohan's seizure activity in early June, as blood is irritating to the surface of the brain. R8.29, 37. During his testimony, Dr. Frim displayed and described some of the MRI images that had been taken at CMH. R8.43-50.

Dr. Frim diagnosed Yohan as having been born with BEH. R8.16, 51. Dr. Frim has diagnosed and treated up to 100 patients with BEH throughout his career. R10.51-52. Any subarachnoid space that exceeds three millimeters is diagnostic for BEH, R8.45 a benchmark that Dr. Frim first developed through his mathematical model that was the

subject of his peer-reviewed article. R10.42; E14.37. Dr. Frim demonstrated on the June 6 MRI a measurement of Yohan's subarachnoid space that was six millimeters. R8.45.

It was Dr. Frim's expert medical opinion that Yohan's intracranial bleeding was consistent with the pre-existing medical condition of BEH. R8.51. Due to this condition, Yohan was particularly susceptible to bleeding from birth trauma or from trivial or minimal force. R8.51. Dr. Frim testified that many studies have estimated that between 20 to 40 percent of all newborns will have some intracranial bleeding, R8.36, and Dr. Frim has had direct experience treating patients with birth trauma whose symptoms appear several weeks following birth. R10.17-18. Moreover, once a subdural hematoma is present, the likelihood of subsequent bleeding increases due to both the increase in area caused by the hematoma as well as the anti-coagulant agents the hematoma releases. R8.26, 31, 51-52, R10.15.

In his review of the MRI imaging from CMH, Dr. Frim noted the presence of subarachnoid hemorrhages that changed locations between two different days, indicating that the blood in Yohan's subarachnoid space was traveling. R8.29, 33. Due to the blood movement in Yohan's subarachnoid space, Dr. Frim concluded it was reasonable to expect that blood to move into the retinal space and be viewed as retinal hemorrhaging. R8.54. Dr. Frim identified an article by Dr. Joseph Piatt that he had relied upon in assessing Yohan's case, "A Pitfall In the Diagnosis of Child Abuse: External Hydrocephalus, Subdural Hematoma, and Retinal Hemorrhages." R8.56; *see also* Parents' Exh. 23, E14.37-44 (used for demonstrative purposes). Dr. Frim explained that this case study profiled a child with BEH who sustained both subdural hematoma and retinal hemorrhaging from a small amount of accidental trauma; the retinal hemorrhages were caused by blood traveling through the subarachnoid space of the cranium to the enlarged subarachnoid space of the optic nerve and retina. R8.56. Dr. Frim viewed the images and

descriptions of the retinal hemorrhages in Dr. Piatt's article as strikingly similar to the descriptions of Yohan's retinal hemorrhages in the CMH records. R8.58, 61.

In Dr. Frim's expert opinion, non-accidental trauma was not the most likely causative explanation for Yohan's intracranial bleeding. R.52, 71. He explained that in the absence of any reported trauma, it was not reasonable to conclude that abuse was a more likely explanation for the intracranial bleeding than a non-abuse explanation, particularly with a five-week-old infant with BEH. R8.52, 71. Additionally, in Yohan's specific case, the absence of any marks on his scalp, head, or skull and the absence of injury to his brain indicated that even if external trauma had caused Yohan's intracranial bleeding, it was unlikely that it was severe trauma. R8.84. Dr. Frim opined that there was an adequate neurosurgical basis based upon the anatomy of the subarachnoid space that the existence of BEH in Yohan explains his retinal hemorrhages, particularly in the absence of any other damage to the retina such as retinoschesis. R8.72-73. Although a simultaneous injury to a child's skeletal system could be relevant to determining whether a child was the victim of abuse, R10.25, the presence or absence of a fracture is not relevant to a neurosurgical diagnosis of BEH or to the potential causes of intracranial bleeding. R8.83; R10.25.

Patrick David Barnes, M.D. Dr. Patrick Barnes, pediatric radiologist and pediatric neuroradiologist, testified as a witness for the Parents. R5.20. Dr. Barnes received his medical degree from the University of Oklahoma in 1973. R5.21; *see also* Parents' Exh. 10, Barnes CV, E13.137-207. Dr. Barnes was board certified in Diagnostic Radiology in 1977 (recertified 2008) and he received Added Qualifications in Neuroradiology when that certification became available (1995). R5.21-22. Dr. Barnes' practice and expertise for the past 35 years has been in the subspecialties of pediatric radiology and pediatric neuroradiology, with a particular focus in child abuse. R5.20, 29.

Dr. Barnes has served as the Chief of Pediatric Neuroradiology at Packard Children's Hospital, Stanford University, since 2002 as well as the Co-Director of the hospital's pediatric MRI/CT center. R5.23; E13.138. Prior to affiliating with Stanford, where he serves as a full Professor of Radiology, Dr. Barnes was the Chief of Neuroradiology and Radiology at Children's Hospital in Boston and an Associate Professor of Radiology at Harvard Medical School. R5.23; E13.137-38. Dr. Barnes has been the recipient of teaching awards from both Harvard and Stanford, and for the past five years U.S. News and World Report has ranked him the top one percent of physicians nationwide in the specialty of pediatric neuroradiology. R5.35-36; E13.45-44.

Dr. Barnes has published several hundred peer-reviewed articles and research and serves on the Editorial Board for medical journals such as *Journal of Child Neurology* and *Pediatric Radiology.* R5.34, 36; E13.144-45. In 1998, Dr. Barnes co-authored two chapters with Dr. Paul Kleinman in his classic book *Diagnostic Imaging of Child Abuse.* R5.30-31. Since 1992, Dr. Barnes' neuroradiological work has focused on injury, including abusive injury, to the developing brain of the fetus, newborn, and young infants. R.37; E13.148-49. While at Stanford, Dr. Barnes co-founded the hospital's Suspected Child Abuse and Neglect Team as well as the Northern California Task Force on Child Abuse. R5.24.

Dr. Barnes' child abuse focus has included examining and identifying conditions and findings that mimic the signs of child abuse in radiological imaging studies. R5.33-34. In 2011, Dr. Barnes published in *Radiologic Clinics of North America* his peer-reviewed article "Imaging of Nonaccidental Injury and the Mimics: Issues and Controversies in the Era of Evidence-Based Medicine." R5.38; Parents' Exh. 11, E13.208-32 (admitted for limited purpose of expert qualification, R5.42). This article includes Dr. Barnes' study and research surrounding the condition BEH and birth issues related to intracranial bleeding.

R5.43-44. Dr. Barnes has extensive clinical and academic experience with BEH, having first authored an article about this condition in 1987, E13.171, and having diagnosed hundreds of patients with BEH during his career, R5.51.

Dr. Barnes' above-referenced article also discusses conditions impacting the skeletal system that mimic findings commonly associated with child abuse. R5.43. Since beginning his practice in the 1970s, Dr. Barnes' work has included the diagnosis and identification of rickets. R5.49. In 2008, Dr. Barnes co-authored a peer-reviewed article "Rickets vs. Abuse: A National and International Epidemic," published in *Pediatric Radiology*. R5.33; Parents' Exh. 12, E13.233-39 (admitted for limited purpose of expert qualification, R5.47). Rickets is more rarely diagnosed than BEH; Dr. Barnes sees between six-to-twelve rickets cases in his clinic per year. R5.51. Dr. Barnes has diagnosed thousands of bone fractures through his career. R5.52. The court qualified Dr. Barnes as an expert in both pediatric radiology and pediatric neuroradiology, as well an expert qualified in the areas of imaging of child abuse and the mimics of child abuse. R5.57.

During his testimony, Dr. Barnes displayed and explained the imaging that had been taken of Yohan's head while at CMH, particularly numerous images from the June 6 CT scan and the June 6 MRI. R5.88, 107; Parents' Exh. 31, E14.116-18 (authentication of CDs). Dr. Barnes identified prominent subarachnoid spaces in the front part of Yohan's head, which he explained were "benign extracerebral collections" (*i.e.*, BEH), R5.96, 110, that were larger than normal and contained CSF. R5.114-15. Dr. Barnes identified the very small posterior blood noted in the CMH radiology reports, which Dr. Barnes explained could represent either a hemorrhage or thrombosis (*i.e.*, clotting within the vein), R5.93, 110, 118, likely located in the subdural space, R5.113. The very small nature of this subdural blood is characteristic for bleeds related to BEH. R5.119.

On the June 6 scans Dr. Barnes saw the small foci of blood in the left frontal area noted in the CMH reports, which Dr. Barnes labeled either a subarachnoid hemorrhage or thrombosis in a cortical vein. R5.97, 120, 122. Dr. Barnes also noted microscopic blood on the posterior right side characteristic for cortical brain thrombosis and, in the June 9 MR venogram without contrast, an asymmetry of the smaller cortical veins, suggestive for cortical venous thrombosis, R5.116-17, 120, 179. In the presence of BEH, cortical venous thrombosis can cause subdural hemorrhaging. R5.180-81. Individuals who are vitamin D deficient are predisposed to venous thrombosis, not an uncommon condition in infants under one year of age. R5.183, 228. A thrombophilia blood work-up would have assisted in assessing Yohan's propensity for venous thrombosis. R5.182.

Dr. Barnes opined that Yohan had imaging findings consistent with BEH since birth. R5.185-86. Because infants with BEH are susceptible to bleeding spontaneously, from minimal force, or from concurrent medical conditions such as venous thrombosis, it was Dr. Barnes' expert opinion that Yohan's intracranial bleeding was most reasonably explained by the pre-existence of BEH. R5.187-88.

In his review of the June 6 head imaging, Dr. Barnes identified some of the findings in the skull that are indicative of congenital rickets. R5.101. Specifically, the irregularities in the bones adjacent to Yohan's sutures (the normal soft gaps found in the skulls of infants) represented incomplete bone formation and insufficient bone thickness, a condition called craniotabes that is often seen in infants with congenital rickets. R5.102-03, 106; Barnes Report, E14.8. The specific irregularity found in Yohan (appearance of "little bites") is a characteristic finding of rickets long-reported in the medical literature. R5.104, 106. The craniotabes was confirmed by the skull images from the June 23 skeletal survey, which also revealed incomplete bone formation in Yohan's teeth and jaw. R5.133-35, 139-40.

During his testimony, Dr. Barnes displayed various images from Yohan's June 23 bone survey. R5.133. Dr. Barnes referenced the June 23 images because of the poor quality of the images from the June 8 skeletal survey relied upon by Dr. Nicholas. R5.145. Dr. Barnes identified many abnormal findings characteristic for congenital rickets including fuzziness at the growth centers (metaphysis, R5.150) of both ankles, R5.136, 138, bowing in the tibial bones of both legs, fuzziness at the growth centers of both knees, R.143-47, and incomplete growth pattern in both the right and left ribs known as rachitic rosary, R.152-53.

In the growth center, or metaphysis, of Yohan's distal left femur, Dr. Barnes identified characteristic findings of rickets, noting the findings were more severe in the left knee than the right knee. R5.147-48. He did not see a fracture to either the medial or lateral aspect of Yohan's left distal femur, R5.147-48, or evidence of periosteal reaction indicative of a traumatic fracture. R5.190. Dr. Barnes explained that the radiographic indicators of congenital rickets can mimic the appearance of a so-called "classic metaphyseal fracture," a fracture that some practitioners have maintained is specific to child abuse. R5.148, 189. Also, rickets that is evolving or in the process of healing can mimic the signs of periosteal reaction. R5.148. It was Dr. Barnes' medical opinion that Yohan had findings consistent with congenital rickets, which can produce findings that mimic abuse, and that Yohan had no fracture or healing fracture to his left femur. R5.188-90.

Christopher Sullivan, M.D., M.P.H. Dr. Christopher Sullivan, pediatric orthopedic surgeon at the U. of C.'s Children's Hospital where he serves as the Director of Pediatric Orthopedics and Scoliosis, testified as a witness for the Parents. R5.243; *see also* Parents' Exh. 15, Sullivan CV, E14.15-20. Dr. Sullivan's undergraduate degree in Physics, which he obtained from the U.S. Air Force Academy where he graduated in the top one percent of his class, R5.244; E14.15, included specialized study of how loads and forces cause the

failure of structures. R5.245. Dr. Sullivan received both his medical degree and Masters in Public Health from UCLA, R5.244; E14.15, and he was board certified in Orthopedic Surgery in 1986 (re-certified in 2006). R5.245-46; E14.17.

Dr. Sullivan specializes in the practice and instruction of pediatric orthopedic surgery, R6.2. Dr. Sullivan's patients have a growing skeletal system and, therefore, he is also familiar with conditions that impact bone growth, including rickets. R6.9. He is an Assistant Professor at the U. of C. in both the Department of Surgery and the Department of Pediatrics. E14.17. Throughout his career, Dr. Sullivan has conducted approximately 7,000-8,000 pediatric orthopedic surgeries. R6.2. Dr. Sullivan has a number of peer-reviewed articles, E14.18, and serves as a Peer Reviewer for the medical journal *Clinical Orthopaedics and Related Research.* R5.246; E14.17. Dr. Sullivan has attended specialized trainings on issues surrounding child abuse, E14.20, has published two articles addressing the topic of how child abuse relates to fractures, has given numerous presentations on the issue of child abuse-related fractures, and serves on the U. of C.'s child protection team. R5.246-48. Dr. Sullivan is familiar with the condition of congenital rickets and has treated several dozen children for rickets-related problems. R6.7-8. The trial court qualified Dr. Sullivan as an expert in both pediatric orthopedics and in bone fractures. R6.10.

During his testimony, Dr. Sullivan displayed a side-by-side comparison of the x-ray of Yohan's left knee from the June 8 and June 23 skeletal surveys. R6.20. He identified the very edge and corner of the distal femoral metaphysis at question in this case and explained that the June 8 image contains a very tiny irregularity that differs from the appearance of a fracture, which would be more disruptive and more apparent. R6.24. Dr. Sullivan also identified a similar slight irregularity on the June 8 image in the part of Yohan's tibia closest to the knee joint. R6.25. Dr. Sullivan did not identify any fracture to Yohan's left distal

femur in either the June 8 skeletal survey, or the June 8 radiographs of both knees (which were not of good quality), or the June 10 radiograph of the left knee. R6.15-16, 24, 31-32.

The absence of clinical observations corroborating the presence of a fracture is also significant. R6.38. A bone fracture is painful and causes a patient to avoid moving the leg. R6.38, 43. The June 23 x-rays, however, reveal that the splint that had been applied to Yohan's left leg, which should have bridged the knee at the time it was applied, R6.56, had slid down, suggesting that Yohan was moving his left knee around. R6.33, 37-38, 41. Though some fractures to non-verbal children can be missed due to subtle symptoms, there will be observable tenderness if a patient is pressed on the area of a suspected fracture. R6.43. In all of the medical records Dr. Sullivan reviewed from June 6 through August 12, there was no report of tenderness over Yohan's left distal femur. R6.39-40.

As to the June 23 image, Dr. Sullivan identified an irregularity in the distal femoral metaphysis that was a classic finding for irregular calcification of normal bone growth, or rickets. R6.26-27. The changes in the femoral metaphysis looked very irregular—more so than the irregularities in the June 8 image—and the left tibia also showed evidence of irregular ossification near the knee joint, consistent with rickets. R6.27, 29. Dr. Sullivan demonstrated that the June 23 image did not contain signs of true periosteal reaction, which if present would appear as a faint onionskin-like layer along either side of the metaphyseal area. R6.27-28. Even if there were periosteal reaction present, however, it is commonly seen along bones in children that are experiencing rapid growth. R6.64.

Dr. Sullivan explained that any fracture, even a so-called "classic metaphyseal fracture" (a term not used by orthopedic surgeons), is going to have evidence of healing and the absence of periosteal reaction indicates that a fracture never existed. R6.44. Dr. Sullivan's expert medical opinion was that Yohan had no evidence of a fracture. R6.62.

Lay Testimony

In addition to the testimony of Teresa G. and K.S., which was consistent with the facts as stated *supra*, the following lay witnesses testified:

Vinay Couto Mr. Couto, who has lived in Chicago for 18 years and works as a senior partner with a global management consulting firm, is Teresa G.'s first cousin. R8.243-245. Mr. Cuoto and Teresa have a close relationship, R8.246, and their families, always including the children, gather every month. R8.248-47. Mr. Couto knows Teresa to be a calm, deeply spiritual, caring, and compassionate person. R8.248-49. K.S. is "ideally-matched" to Teresa as he is also a calm, considerate person having a wonderful demeanor with children. R8.249. Mr. Couto described Teresa and K.S. as patient, gentle, and thoughtful parents who are very proud of their children and concerned for their well-beings. R9.2-5. Mr. Couto visited the family at CMH; the Parents were distraught and bewildered about Yohan's medical issues. R9.5-6. Mr. Couto observed Yohan with his cast and was surprised by him moving his left leg so freely without expressing any pain. R9.6.

S. Rao Seteigunte Ramachandramurthy By stipulation, K.S.'s father Mr. Ramachandramurthy knows K.S. as a caring and charitable person, Teresa as a kind and compassionate person, and both as loving, gentle, and affectionate parents. R11.107-09. On June 18, 2011, Mr. Ramachandramurthy became a relative foster parent for Yohan and Marika; between June 18-June 24 he observed Yohan move and kick his left leg from the knee many times, causing the cast to slide down. R11.110-11. When he would touch Yohan on his left leg during this period, Yohan did not exhibit any pain. R11.111.

Rashmi S. Rashmi is K.S.'s sister and works as a software engineer in Bangalore. R8.197-98. She knows Teresa and K.S. to be loving, nurturing, gentle, and calm parents who do not express anger or frustration with their children. R8.201-03, 205-06, 207, 209-

10. When Rashmi stayed with the family in June, 2011, she observed Yohan exhibiting a strange expression where his eyes would roll up. R8.211-12.

Tobey Benas Ms. Benas lives in the same building as Teresa, K.S., and their children. R6.142. She first met the family when Teresa was pregnant with Marika, and since that time they have grown to be like family, spending time together three to five days a week and sharing many meals. R6.142-44. Ms. Benas has had many opportunities to observe K.S. and Teresa with their children, and knows them to be protective, loving, kind, and respectful parents who have never raised a voice to either child. R6.144, 146, 148, 151.

Rev. John P. Boivin Rev. Boivin has been a priest for 36 years, the last 17 of which have been as an associate pastor at Holy Name Cathedral. R6.133. Rev. Boivin has seen the family of K.S. and Teresa almost weekly for the past three years, and has had dinner at their home on at least six occasions. R6.134-35. He has never seen Teresa and K.S. without their children, and they are a very affectionate family. R6.135, 138. Rev. Boivin offered that the Parents have a "serenity" about them and that "[t]here's just a gentle spirit about her and about him." R6.136.

Fatima G. Fatima is Teresa's mother and beginning in September 2011, was a relative foster parent for Marika and Yohan. R9.12. Fatima knows Teresa to be loving, gentle, respectful, and religious. R9.14, 19-20. Following the birth of Marika, Fatima stayed with the family for five months. R9.22. Both Teresa and K.S. love children, and they are caring parents to both Yohan and Marika. R9.22, 31.

Leena Reddy Ms. Reddy is a childhood friend of Teresa, she has known K.S. since 2006, and she is a godparent to Marika. R9.48-49, 51. While living in Wisconsin, Ms. Reddy saw Teresa, K.S., and Marika every weekend. R9.50-51. Ms. Reddy is "amazed" by how patient and loving Teresa and K.S. are with their children. R9.52. Since moving to

Cleveland, Ms. Reddy sees the family every week through 30-60 minute Skype calls. R9.53, 62. When Yohan was in the hospital, Ms. Reddy spoke with both Teresa and K.S., who each expressed sadness, concern, and worry about Yohan's health. R9.58-60.

Ruling

On August 1, 2012, the trial court issued its written adjudicatory ruling. E10.215-217. The court began by stating, "this has been an extremely difficult case . . . to decide," and noted that "mother and father are loving and responsible parents . . . [t]hey nurture [their children], play with them, read to them, and care for them in every way." E10.215.

The court credited Dr. Janicki's and Dr. Nicholas's diagnosis of a knee fracture, and attributed such a diagnosis to Dr. Fortin as well, over the testimony of Dr. Sullivan and Dr. Barnes, neither of whom visualized a fracture or signs of a healing fracture and both of whom detected findings consistent with rickets. E10.216. The court averred that all parties agreed the subsequent existence of periosteal reaction confirms the diagnosis of a fracture, which Drs. Janicki, Nicholas, and Fortin claimed to be present on the June 23 imaging. (*But see supra* pp. 26, 39). The court noted that Dr. Nicholas did not see evidence of rickets on the imaging she reviewed. *Id.* The court claimed all parties agreed blood tests could confirm the presence of rickets, and that all of Yohan's levels were found to be in the normal range except for vitamin D. *Id.* Based on this understanding of the evidence, the court concluded that Yohan suffered a fracture of his left distal femur and that he did not have rickets. *Id.* The court then reasoned that because there was no accidental explanation for the fracture, the fracture must have been caused by abuse. *Id.* The court postulated that perhaps the imaging of the periosteal reaction could be unclear enough so as to prevent the finding of a fracture, but only in the absence of the other medical findings. E10.217.

As to Yohan's intracranial bleeding and retinal hemorrhages, the trial court discounted the testimony of Dr. Frim that Yohan had BEH predisposing him to bleeding in the head that can then travel to the eyes, E10.215, on the basis that Dr. Frim did not consider a fracture to be relevant to his neurosurgical diagnosis. E10.217. The trial court made no mention of Dr. Barnes' testimony and report regarding the diagnosis of BEH and its likely contributions to Yohan's medical findings. E10.215-17. The court also relied on the testimony of Dr. Mack for the supposition that Yohan did not have any bleeding or clotting disorders. *Id.*

The court concluded that what was most indicative of abuse in this case was the number of "injuries" that existed: intracranial bleeding, retinal hemorrhaging, and a fracture. E10.217. Per the court, the Parents' witnesses were only able to provide separate non-abuse explanations for each "injury," as opposed to a single medical explanation for all three, and the court deferred to the State and GAL witnesses that there existed a so-called "constellation of findings" for non-accidentally inflicted trauma. E10.217. The court closed its analysis by concluding that perhaps it could be persuaded that BEH and birth trauma were responsible for Yohan's intracranial and retinal bleeds, and perhaps it could be persuaded that the radiographic evidence was so unclear as to prevent a finding of a fracture, but "for the court to conclude that all three of these infrequent to rare conditions came together at the same time to explain this minor's condition is not reasonable." E10.217. As such, the court found that the State had met its burden of proving that Yohan had suffered physical abuse and that, by extension, the State had also proven an injurious environment and substantial risk of physical injury to both Yohan and Marika. *Id.*

F. Evidence and Ruling at the Dispositional Hearing

Julia Bolden The dispositional hearing commenced on September 14, 2012. R12.32. The State first called DCFS caseworker Julia Bolden to testify. *Id.* She testified that both parents were receiving therapy, were consistent and cooperative with the therapists, and "had addressed the issues that brought the case into court." R12.37, 48, 66, 67. Ms. Bolden's supervisor directed her to revise the therapy referral at the end of May to specify that the findings of abuse by the juvenile court needed to be "discussed" or "processed" in therapy. R12.42, 43. Both therapists modified their therapy to comport with this revised referral. R12.45. In August 2012, the father's therapist recommended couples therapy for the parents, which started on September 13, 2012. R12.49, 51.

Ms. Bolden testified the parents live in the same apartment building complex as the grandparents/foster parents, but stay overnight with their downstairs neighbor Tobey Benas (sleeping on the floor) when not having their twice-weekly overnight visits. R12.55-56, 88. They also have supervised day visits, with Teresa spending most of the day with the children and K.S. joining the family every day after work, R12.55-56, except they have been allowed to walk Marika to school unsupervised. R12.82. There had been no signs of any maltreatment of the minors during any of these visits or otherwise. *Id.* at 55-56. The parents were responsible in ensuring all appropriate doctor visits for the children, and they responded appropriately to their children as "caring and protective parents." R12.81.

When the dispositional hearing commenced, DCFS's position, articulated by Ms. Bolden, was that the children should be placed into the guardianship of DCFS and made wards of the court. This position was not based on any safety concern, R12.91, but on the view that "some family therapy would be beneficial" and "having some unsupervised day visits . . . would also be beneficial for them." R12.52, 85. She stated that DCFS might be

ready to recommend a full return home as soon as "two weeks from now." R12.85, 89-90. As of September 14, DCFS recommended one additional supervised overnight and up to six hours per day of unsupervised day visits, a request supported by the Parents' therapists. R12.56-57, 83. Ms. Bolden was aware the prior DCFS caseworker, as well as the Parents' therapists, had recommended return home before the adjudicatory hearing. R12.61-62

Ms. Bolden's testimony was completed on October 30, 2012. R12.102. In the interim, the court increased the Parents' visiting time to include four nights of supervised overnight visits and two days of unsupervised day visits, based on the Parents' compliance with services, the witness' testimony about the "natural progression" of similar cases, and the best interests of the minors. R12.105-6, R13.34. There were no problems following these modifications. R12.34-37. Due to this change, Ms. Bolden testified on October 30 that DCFS was now recommending that the children be returned home. R12.38.

Helen Evans, Ph.D. The State called psychologist Dr. Helen Evans, who has 31 years of experience and a doctorate in clinical psychologist, R12.173, to testify regarding her therapy with Teresa G. Dr. Helen Evans treats adults and children, 20 percent of whom (and at least 200 of whom) have been DCFS-involved, R12.114, 175, and 70 percent of whom are children, R12.114, with 80 percent of her adult DCFS-involved clients having been found to be a perpetrator of abuse or neglect, R12.117, including some cases with "unknown" perpetrators. R12.118. She was on the expert panel for DCFS referrals. *Id.*

Before beginning therapy, Dr. Helen Evans was given the integrated assessment, the medical records, and opinions of doctors as to Yohan's injuries. R12.120-22. She also reviewed prior psychiatric evaluations and testing by other psychologists. R12.188-93, 194, 201, 203-06; *see also* Parents' Exh. 3, Mental Health Evaluation by Dr. Robert L. Rosenfeld, E13.121-22 (report dated 9/1/11, finding parents posed "no immediate nor

remote threat of harm to their children"). She formed her treatment goals based on the skills and insight she felt Teresa needed to be reunited with her children and provide a safe and effective environment for them. R12.142. Her initial goals were to "help the mother cope with DCFS involvement, understand how her child was injured and how to keep him safe in the future." R12.124. Treatment goals are meant to help "enhance your client's effectiveness and their performance in life. . . or giv[e] them some kind of insight into who they are," R12.142-43, and help them to "parent effectively," R12.133.

The first goal of Teresa's therapy was to review her life history and how it impacted her parenting. R12,127. The next goal addressed helping Teresa cope with the stress of DCFS involvement. *Id.* Because research shows that parental instability is a risk factor, *id.* at *555*, one purpose of Teresa's individual therapy was to assess her "present emotional state" and whether she was "emotionally stable." R12.154. In August 2012, Dr. Helen Evans was given the adjudication findings, which she incorporated into the therapy and discussed with Teresa at every subsequent therapy session. R12.124-25, 151.

Following the adjudicatory ruling, Dr. Helen Evans added the goal of reunification and developing a safety plan to assure Yohan's safety for the future. R12.128-29, 169. This goal was added because Teresa maintained she was not the perpetrator and "if the perpetrator is unknown," then the question is how to keep the child safe. R12.130. Dr. Evans did not consider it to be her role to convince Teresa of someone else's opinion—"[u]nderstanding that the injuries were inflicted" was not the treatment goal; keeping the child safe was. R12.143. Nor did Dr. Evans feel qualified to determine the identity of the perpetrator, or to determine whether Teresa was the perpetrator. R12.153, 216, 222 (explaining limitations on therapist's role). Rather, Dr. Evans' role was to help Teresa "parent effectively" in light of the fact a child had been injured. R12.133. Even so, the

therapy addressed the possibility that Teresa was a perpetrator by assessing her knowledge of child development, identifying age-appropriate redirection, stress and parenting roles, and household management. R12.136; *see also* R12.182-184 (Teresa's claims of innocence did not interfere with addressing the issues and she was not resistant to any suggestions made through therapy). Dr. Helen Evans also believed that even if K.S. had perpetrated the abuse, Yohan could be safe around him if he had received therapy. R12.160.

Dr. Evans found that Teresa had a lot of parenting knowledge and skills, R12.136, 219, managed stress well, R12.225, is "very observant," R12.137, and had good communication with her husband, R12.225. She found Teresa G. presented no risk with regard to her understanding of appropriate discipline and ability to manage stress, and found Teresa to be a conscientious and responsible parent. R12.138-38, 168; *see also* Parents' Exh. 4, Teresa G. Progress Report, E13.125-29. In light of Teresa's spirituality, Dr. Evans also addressed the use of prayer for stress management. R12.139. While Teresa possessed these skills at the outset of therapy, as demonstrated by "several assessments of her by licensed clinical psychologists and psychiatrists," and she needed "very little treatment," Dr. Evans worked on helping her monitor her own internal physiological responses to stress. R12.139, 156, 213-14. Teresa had made progress in keeping her child safe, and Dr. Evans was ready to terminate therapy with Teresa, as she had accomplished the treatment goals. R12.148-49. 215. Her opinion was that Teresa had adequate parenting skills, was emotionally stable, had adequate child support in place, and presented no concerns of being a danger to her children or being unable to protect them. R12.149, 215-16. Dr. Evans supported the goal of return home. R12.211.

The court took judicial notice of prior psychological testing that showed Teresa presented no risk of abuse towards her children. R12.188, 190, 193 (C2.35, E10.155-60,

Interaction Dynamics, Psychological Evaluation of 11/14/11, previously admitted into evidence 4/13/12). The report found both parents had strong coping skills, received tremendous support from their family, and were well-adjusted individuals. R12.193.

Robert Evans, Ph.D., LCSW The State next called Dr. Robert Evans, a licensed clinical social worker with a doctorate in social work and 40 years of experience in counseling individuals and families, R12.226, R13.6, including 20 years of experience in the child welfare field in Chicago, R13.9. He had worked with admitted child abusers and attended conferences on treatment of male abusers. R13.10. He testified that it is generally accepted that there are certain conditions that may lead to child abuse, and Dr. Robert Evans evaluated K.S. for these conditions. R13.11. He conducted a broad enough assessment so as to encompass a person who injured his child purposefully, though he did not consider K.S. to be such an individual or to pose a risk to his son. R13.12-15. He treated K.S. weekly for about six months. R12.227, 242. He received a court assessment of the family and a statement from the DCFS worker of issues to be addressed, along with evaluations of K.S. and medical reports. R12.228-230. Dr. Evans had reviewed the judge's findings and understood that the judge "could not determine who may have caused the injuries." R12.231. Dr. Evans thought K.S. could be ruled out as an abuse perpetrator based on his experience and looking at profiles of persons who are likely to cause abuse. R12.235, 239, R13.26. This belief was based, in the first instance, on the mental health assessment he conducted in March or April of 2012. R12.247. After the court's adjudication, Dr. Evans reassessed the factors associated with abusive behavior and concluded he "couldn't explain how the injuries were inflicted or if they were medical," though he believes the child had a medical problem. R12.248-49. The father never told Dr. Robert Evans he thought the mother caused the abuse, R13.2, 26, 31, and Dr. Evans

did not believe that K.S. was protecting the mother. R13.31. His treatment goals were to assess K.S.'s self-understanding and emotionality (anxiety, depression, anger) as it related to his capacity to strike or injure his son, to help him express his feelings about the injuries, and to help him express how he intends to keep his children safe in the future. R12.237-38. He believed that K.S. had successfully completed individual therapy as of August 2012. R12.244. Dr. Robert. Evans couldn't say how he would have treated K.S. differently if he were an abuser because K.S. didn't present in the way "an abuser would present" and in his professional experience, if a person is an abuser, confronting them long enough will lead them to become angry. R13.26, 29, 31.

Dr. Robert Evans opined that the children should return to the care of their parents, R12.245, with court monitoring for 3-6 months. R13.15. The family had met all of its goals in family therapy; the parents exhibited calmness and patience, which the children's behavior reflected; and the parents had a good bond with the children and were attentive to them. R13.18-24. Dr. Evans had provided that same opinion prior to the adjudication. R13.7; *see* Parents' Exh. 5, K.S. Progress Report, E13.130-33.

Positions of Parties at Conclusion of Dispositional Hearing

At the conclusion of the disposition hearing, the State argued that there continued to be "risk" in light of the court findings and asserted that the Parents "did not make progress" despite the recommendations of both therapists. R13.40-41.The State asserted that Dr. Robert Evans "was not conducting therapy." R13.43. The State acknowledged the children and parents seemed to be "doing fine when they're together." R13.44. The GAL concurred that the parents had not received "meaningful therapy" even though they were cooperative and willing to participate in services, just as they had been at the hospital. R13.45. The Parents argued that under the standards pressed by the State and GAL, they

"will never ever make the progress they're requiring" and that the Parents had multiple expert evaluations showing they posed no risk of harm to their children. She noted the judge had not had sufficient evidence to identify the Parents as the perpetrator, and that no amount of therapy was going to get them to say they hurt their child. R13.53-54.

Ruling

The juvenile court found that the parents had complied with all the services they had been asked to complete and noted the DCFS recommendation of return home along with the lack of any unusual incidents. R13.55-58. The trial court rejected the State and GAL's position that a more confrontational style of therapy was required. R13.58. He noted 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." R13.58-59. The court entered a dispositional order finding the parents fit, able and willing to care for, protect, train and discipline the minors and concluding it was not in the minors' best interests to be made wards of the State, R13.59; C4.166, C9.189, and entered a companion order of protective supervision, C4.165, C9.188.

Neither the State nor the Parents appealed from the dispositional order. When the GAL filed its notice of appeal, the Parents exercised their right to challenge the underlying adjudicatory findings of abuse and neglect by filing a timely cross-appeal. A.8-11.

ARGUMENT

In the proceedings below, the trial court was understandably challenged by the medical science involved in this case. Experts disagreed on critical facts and in several instances, tests that might have illuminated Yohan's condition were not performed. Even so, there were only a few key areas in which sharp dispute existed. As to those areas, the trial court erred in its assessment of the weight of the medical evidence, in allowing opinion

to be offered by doctors who did not have the requisite expertise in the area at issue, or by discounting the opinion of the Parents' experts for reasons that were not valid. The trial court also assumed facts that were not proven (*i.e.*, that a connection must necessarily exist between the head-related findings and the leg-related findings) and drew inferences from these factual conclusions that were incorrect. As to those areas of sharp dispute, the evidence in support of a medical explanation for Yohan's conditions was overwhelmingly strong whereas the evidence supporting a finding of abuse was weak, non-existent, and/or conflictual. Finally, because there was no evidence of an abusive action, the court's finding of abuse was legally erroneous.

I. THE CENTRAL MEDICAL DISPUTES AT ISSUE.

A. Yohan Had Pre-Existing Benign External Hydrocephalus.

Neither the trial court nor Dr. Fortin ever disputed the diagnosis of BEH. R4.159. Only two doctors—Dr. Wainwright and Dr. Burrowes, neither of whom possessed *any* expertise in the condition—questioned the validity of the BEH diagnosis. Parents' expert Dr. Frim is a pre-eminent, nationally-renowned neurosurgeon with unsurpassed credentials in his field. Frim CV, E14.61-110. Dr. Frim possesses highly specialized expertise in the diagnosis and understanding of BEH. *See* Facts *supra* pp. 29-30. He clearly explained that the existence or non-existence of an injury on another system of the body is not relevant to a neurosurgical diagnosis of BEH, R8.83. Yet, the trial court improperly used this medically irrelevant issue to discount Dr. Frim's opinion, E10.217, rather than defer to the expertise of Dr. Frim as to what criteria are valid in rendering a neurosurgical diagnosis. Dr. Frim unequivocally diagnosed Yohan as having pre-existing BEH based upon the objective measurement criteria of Yohan's subarachnoid space exceeding three millimeters. R8.16, 45, 51, R10.42.

Dr. Barnes similarly possesses outstanding credentials and significant clinical and academic expertise in the specific condition of BEH, Facts *supra* pp. 33-35, and provided strong corroboration of this diagnosis. Of note, the trial court entirely overlooked Dr. Barnes' opinions regarding BEH. In addition to identifying the larger-than-normal, CSF-filled subarachnoid spaces diagnostic for BEH, R5.96, 110, 114-15, Dr. Barnes noted that the very small nature of Yohan's intracranial blood was characteristic for bleeds occurring secondary to BEH. R5.119.

Dr. Wainwright–who has seen only two cases of BEH, R2.208–conflated the presence of BEH with the question of BEH as a causative explanation for *all* of Yohan's medical findings, remarking that he did not think Yohan had BEH because it wouldn't account for the other alleged injuries. R2.150. He quickly acknowledged, however, that none of the medical literature supported taking into account other systems of the body when making a determination as to the presence of BEH. R2.152.

BEH is diagnosed based upon radiological findings. R2.209. The measurements of Yohan's subarachnoid space on June 6 ranged from *six to seven* millimeters, R8.45 (Dr. Frim); R8.153 (Dr. Burrowes), which is diagnostic of BEH. Dr. Frim, who is a recognized expert on BEH, identified three millimeters as the proper benchmark and provided ample support for that benchmark in the scientific community. In addition to confirming that benchmark through his own research, R10.42, Dr. Frim identified several peer-reviewed articles that support this benchmark, including articles in the *Archives of Diseases in Children, Pediatric Neurology*, and *Radiology*. R10.50-51. Dr. Frim's chapter from the textbook *Principles and Pediatric Neurosurgery* advises practitioners to use three millimeters as the minimal starting measurement. R10.42. Dr. Burrowes was the only doctor who questioned the diagnosis of BEH based upon Yohan's cranial imaging. Her

opinion, however, was fundamentally flawed in two respects. First, she applied a diagnostic standard (greater than ten millimeters) that has no basis in neurosurgical or neuroradiological science and, rather, was based on her own independent determinations. R8.163-64. The standard of ten millimeters that Dr. Burrows purported to offer is one Dr. Frim has never known any diagnosing physician to use. R10.53.

The second deficiency that disqualifies Dr. Burrowes' opinion that she viewed only a single study from a single date. R8.173. Both Dr. Frim and Dr. Barnes, in contrast, reviewed *all* of Yohan's cranial imaging studies. E14.7-13 (Barnes Report); E14.111-12 (Frim Report). Moreover, unlike both Dr. Frim and Dr. Barnes, Dr. Burrowes has never published any writings about BEH, has never spent any of her career researching BEH, and simply is not an expert on the condition. R8.162, 167.

B. Yohan Had No Radiographic Evidence Diagnostic for a Fracture and No Clinical Symptoms of a Fracture.

Dr. Barnes and Dr. Sullivan, two accomplished specialists from esteemed teaching hospitals, Stanford and U. of C., respectively, with a combined sixty years of experience diagnosing pediatric fractures, both testified that Yohan's x-ray imaging did not show a fracture to his left femur. See Facts *supra* pp.37, 39. Dr. Sullivan, who has diagnosed up to 1,000 pediatric femur fractures, R6.5, and who the court qualified as an expert in bone fractures, R6.10, explained that a fracture would appear differently from the slight irregularity present on Yohan's x-rays. R6.24. Dr. Barnes, who the court qualified as an expert in the imaging of child abuse and in the mimics of child abuse, R5.57, also did not visualize a fracture to Yohan's left femur. R.147-48. Rather, Yohan had congenital rickets, which can *mimic the appearance* of a metaphyseal fracture R5.148, 189; *see infra* pp.60-61.

Although two recently-certified CMH doctors[3] diagnosed Yohan as having a fracture to his left femur—Dr. Nicholas and Dr. Janicki, whose dating of the fracture, had it actually existed, would mean that it occurred while Yohan was at CMH, R3.59-60—neither of those doctors identified an actual fracture. None of the imaging of Yohan's left knee (June 8 skeletal survey, E12.131; June 8 isolated x-ray, E12.131; June 10 isolated x-ray, E12.125; and June 23 isolated x-ray, E12.123) contained a positive identification of a fracture, merely noting an irregularity that *could* be a fracture. Indeed, Dr. Nicholas' interpretation of the June 8 skeletal survey also claimed findings suspicious for rib fractures—a reading that was shown to be demonstratively wrong as Yohan had no rib fractures. R7.190; E14.22-24 (Sullivan Report).

Drs. Nicholas and Janicki's diagnosis depended upon the appearance of what they perceived to be periosteal reaction on the June 23 imaging. Even this indirect method of diagnosis, however, was undermined as Dr. Barnes and Dr. Sullivan, with their years of experience reading x-rays and diagnosing fractures (and Dr. Sullivan's years of experience treating fractures through the healing process), both testified to the absence of any periosteal reaction indicative of a healing fracture. R5.190, R6.27-28. Moreover, all of the experts (Drs. Barnes, R5.148; Sullivan, R6.64; Janicki, R3.116; and Nicholas, R7.214-15) agreed that periosteal reaction can exist for reasons other than a healing fracture, making the court's assertion that "all parties agree that the existence of periosteal reaction . . . would confirm the diagnosis of a fracture" to be demonstrably false.[4] E10.216. On the

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[3] The court claimed that Dr. Fortin also diagnosed a fracture. However, it was clear from her testimony that this diagnostic opinion was beyond her expertise. R4.5, 29-30, 51-52. Dr. Fortin herself testified that she relied upon the orthopedist and radiologist for diagnosis of the fracture. R4.118.

[4] Though Dr. Fortin claimed that the existence of periosteal reaction would confirm the existence a fracture, given that this opinion differed from those of the orthopedists and

contrary, both pediatric orthopedists agreed that the *absence* of periosteal reaction would indicate that there never was a fracture to begin with.[5] R3.49 (Dr. Janicki), R6.44 (Dr. Sullivan).

Drs. Sullivan and Janicki also agreed that had there been a fracture, Yohan would have exhibited some pain or distress.[6] R3.116-17, 121, R638, 43. According to the State's own orthopedist, evidence of Yohan moving his leg freely without signs of pain while in the hospital would contraindicate the presence of a fracture. R3.120, 123-24. The State and GAL did not offer a scintilla of evidence that Yohan exhibited any tenderness, pain, or discomfort in connection to his left knee. Rather, the enormous amount of evidence to the contrary—that Yohan was actively moving his left knee during his period of hospitalization and immediately following discharge without any signs of distress, *see* Facts *supra* pp.8, 12-13, 40—overpowers any claim that his left knee was fractured.

C. No Witness Offered a Definitive Mechanism of Injury Consistent with Abusive Causation.

Although the State called three witnesses to provide causation testimony in support of its petition alleging abuse—Drs. Fortin, Wainwright, and Janicki—none of those witnesses actually testified to non-accidental trauma. Dr. Fortin claimed an opinion that Yohan's "constellation of injuries" was due to inflicted trauma, R4.213-20, but that opinion was predicated on her conclusion that no single medical condition could explain all of the injuries. Moreover, she never offered an opinion that the trauma was non-accidental,

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radiologists, the claim only serves to spotlight her lack of expertise rather than substantiate the court's baseless assertion. R4.49.

[5] Dr. Fortin was the sole voice of dissent on this issue—claiming that metaphyseal fractures can heal without signs of healing—again highlighting her lack of expertise. R4.83-84

[6] Again, that Dr. Fortin's proffered general opinion about bone fractures (*i.e.*, that a metaphyseal fracture can be completely asymptomatic, R4.78-79) was at odds with the opinions of the pediatric orthopedists continues to undermine the quality of her opinions.

specifically testifying that she was unable to identify the specific mechanism that caused Yohan's (presumed) fracture, retinal hemorrhages, or intracranial bleeding. R4.204. Similarly, Dr. Wainwright offered an opinion of "inflicted trauma" for Yohan's intracranial hemorrhages, but he did not differentiate between accidental and non-accidental trauma, R2.177, and he stated several times that he was deliberately not identifying a specific type of force and that to identify an exact cause would be "speculation," R2.221, 228. Finally, Dr. Janicki stated that he had no opinion regarding how Yohan's (presumed) fracture occurred, and he had no opinion as to whether an external force would have been accidental or abusive. R3.125-26, 128.

Despite the clear absence of an opinion as to a specific mechanism or accidental v. abusive force, the State elicited the doctors' opinions about what types of forces *could have* caused the various alleged injuries. As to the alleged fracture, Dr. Fortin, who has no specialization in orthopedics or biomechanics, testified the fracture "could" be caused by a shearing force or by a traction force. R4.50-51. Dr. Janicki, who at his deposition had testified to only a potential twisting force, changed his testimony for trial and offered that the mechanism could have been a shaking force or a twisting force. R3.64, 126. He explained his altered testimony by claiming he had conducted "research" in the 24 hours preceding his appearance at trial in an effort to improve the delivery of his testimony. R3.108.

As to the intracranial bleeding, Dr. Fortin, who has no specialization in neurology or neurosurgery, testified that subdural hematomas and subarachnoid hemorrhages "could" be caused by an impact force or by an "acceleration / deceleration" ("a/d") force. R4.34, *see infra* p.57 for discussion on a/d forces and shaking. Dr. Wainwright variously offered as potential mechanisms for the intracranial findings blunt force trauma, shaking,

or suffocation. R2.146-49. Regarding the restricted diffusion, Dr. Wainwright changed his testimony and agreed that "status epilecticus" (*i.e.*, persistent seizing), which Yohan had R2.167, can cause an MRI reading of restricted diffusion. R2.198; E3.14. He also conceded that at his deposition, he testified there was no medical evidence that Yohan had been deprived of oxygen, such as through smothering. R2.221. Under cross-examination, Dr. Wainwright also conceded that he was not alleging blunt force trauma. R2.219.

Regarding the potential cause of Yohan's retinal hemorrhages, the State's evidence was particularly thin. Due to having testified at his deposition that he did not and would not have an opinion as to the cause of Yohan's retinal hemorrhages, Dr. Yoon was barred from sharing an opinion he apparently developed since the time of his sworn deposition testimony. R6.248-7.2. Over Parents' objection, Dr. Yoon was, however, permitted to testify that if a five-week-old infant was subjected to a repeated a/d motion, the forces "could" produce bilateral retinal hemorrhages in multiple layers of the retina, as well as retinoschesis and macular folds. R7.27. Yohan had no retinoschesis or macular folding. R7.69-70. Dr. Fortin, who has no specialization in ophthalmology, also testified that the retinal hemorrhages could have been caused by an a/d force. R4.85.

Drs. Fortin and Yoon never clarified what they meant by "acceleration/ deceleration," but Dr. Frim explained that this language is code for shaking. R8.66. Dr. Frim opined that, based upon research by neurosurgeons and biomechanical engineers examining the forces involved in shaking motions, shaking alone cannot create a sufficient force to break a vein and cause a subdural hematoma. R8.62-63, 65-66. Dr. Frim cited a recent article from *Forensic Biomechanics* showing that the amount of force generated from shaking alone was comparable to the forces involved in daily movement. R8.66.

Drs. Janicki, Wainwright, and Yoon were unable able to testify as to the degree of a/d force that would be required, the number of repetitions that would be needed, or what the weight of the person causing the force would need to be in relation to the person subjected to the force in order to cause the injuries being attributed to Yohan. R2.225, R2.238 (Dr. Wainwright), R7.114-17 (Dr. Yoon), R3.127-28 (Dr. Janicki). Drs. Wainwright and Yoon agreed that there is much controversy regarding the theory that injuries to infants can be caused by shaking alone. R2.226, 238 (Dr. Wainwright), R7.117 (Dr. Yoon). Indeed, significant segments of the medical and legal communities recognize that the theory that certain injuries (such as subdural hematomas or retinal hemorrhages) are indicative of abusive shaking is simply not supported by the science, and many parents and caretakers previously victim to wrongful accusations of abusive shaking are now being exonerated. *See, e.g.*, Keith A. Findley et al., *Shaken Baby Syndrome, Abusive Head Trauma, and Actual Innocence: Getting It Right*, Houston J. Health & Policy (forthcoming, available at the Social Science Research Network, http://ssnrn.com); Deborah Tuerkheimer, *The Next Innocence Project: Shaken Baby Syndrome and the Criminal Courts*, 87 Wash. Univ. L. Rev. 1 (2011); Daniel G. Orenstein, *Shaken to the Core: Emerging Scientific Opinion and Post-Conviction Relief in Cases of Shaken Baby Syndrome*, 42 Ariz. St. L. J. 1305 (2011).

II. THE TRIAL COURT'S FINDING THAT YOHAN SUSTAINED ABUSIVELY INFLICTED INJURIES WAS CONTRARY TO THE MANIFEST WEIGHT OF THE EVIDENCE AND LEGALLY FLAWED.

A. The Manifest Weight of the Evidence Does Not Support a Finding that the Most Likely Cause of Yohan's Medical Findings Was a Non-Accidental Injury.

At an adjudicatory hearing on petitions alleging abuse or neglect under the Juvenile Court Act, the State has the burden of proving the allegations by a preponderance of the

evidence. 705 ILCS 405/1-3(1). On appeal, a trial court's factual findings will be reversed if they are contrary to the manifest weight of the evidence. *In re Barion S.*, 2012 IL App 112026 *41 (1st Dist. 2012). Findings are against the manifest weight "if the opposite conclusion is clearly evident." *Id.* (quoting *In re Arthur H.*, 212 Ill. 2d 441 (2004)). In this case, Yohan ever sustained a fracture, Yohan had a pre-existing medical condition predisposing him to intracranial bleeding and retinal hemorrhages from incidental impact, and the medical opinions ostensibly supporting a theory of abusive causation were vague, equivocal, and uninformed. As such, the trial court's finding that Yohan was abused was contrary to the manifest weight of the evidence.

1. Yohan Never Sustained a Fracture to His Left Knee and, Rather, Had Many Indicators for Congenital Rickets.

The existence of a fracture was essential to the court's finding of abuse—without a fracture the theory of abuse crumbles. Indeed, the only reason the court dismissed BEH as an explanation for Yohan's head-related findings was the (irrelevant, *see infra* pp.62-63) conclusion that BEH could not explain the fracture. Dr. Wainwright was the only State expert qualified to offer any opinion regarding Yohan's intracranial findings, and he testified that if there was no fracture, he would have to reevaluate his opinion of "inflicted trauma." R2.201 Even Dr. Fortin's stated reason for ignoring BEH was her (irrelevant) conclusion that it could not account for the fracture. R4.76-77. Clearly, the type of outcome-oriented analysis applied by the court ***required*** the finding of a fracture in order to sustain any finding of abuse. This dilemma ultimately led the court to ignore the overwhelming evidence of no fracture and disregard the superior expertise of the Parents' witnesses.

As summarized *supra* pp.53-55, the evidence squarely establishes that Yohan never had a fracture. No doctor definitively visualized a fracture on any of the x-rays; though the experts disagreed about the existence of periosteal reaction, they agreed that periosteal reaction can appear in the absence of a healing fracture; a pediatric radiologist and a pediatric orthopedic surgeon both testified to there being no fracture on the x-rays; and Yohan's clinical behavior was completely inconsistent with the existence of a fracture. Based on the manifest weight of this evidence alone, the finding of a fracture by the lower court cannot be sustained.

In addition to inadequate evidence of a fracture, there was significant evidence that Yohan had congenital rickets. Dr. Barnes was the only expert qualified by the court in the mimics of child abuse, and he stated that congenital rickets can be misinterpreted as periosteal reaction and/or a metaphyseal fracture. R5.148, 189. Dr. Barnes is a leading national expert on congenital rickets, having conducted research and diagnoses of rickets for the past 30 years and publishing peer-reviewed articles on this very topic. E13.233-39, E13.208-32. Both of the testifying CMH radiologists, Drs. Burrowes and Dr. Nicholas, know of Dr. Barnes and respect his work, and Dr. Nicholas is aware of his expertise in the area of rickets. R7.196-98, R8.182. Among all the testifying doctors in this case, there was no disagreement that a diagnosis of rickets is made through radiographic findings, which diagnosis can then be supported through lab testing. R5.201-02. Contrary to the assertion of the trial court, no witness testified that blood tests can definitively confirm the presence of rickets. E10.216.

In this case, there were numerous radiological features characteristic of rickets. Dr. Barnes, who was the only witness with highly specialized expertise in rickets, reviewed all of Yohan's scans and found abnormal findings characteristic for congenital rickets in both of

Yohan's ankles, tibias, and knees, as well as Yohan's ribs (rachitic rosary) and skull (craniotabes). *See* Facts *supra* pp.36-37. Dr. Barnes' observations were corroborated through Dr. Sullivan, who also identified irregularities above and below Yohan's left knee that were classic findings for rickets. R6.26-27. The presence of rickets was further corroborated by Yohan's severe vitamin D deficiency and Teresa's vitamin D insufficiency. *See* Facts *supra* p.14. It was undisputed that the most common cause of rickets in infants of Yohan's age is a maternal vitamin D deficiency that is passed to the fetus (*i.e.*, congenital rickets). R5.107. Additionally, contrary to the court's apparent confusion,[7] Yohan had further indicators for rickets including a low serum calcium and a heightened alkaline phosphatase. R4.194-96. Dr. Barnes diagnosed Yohan as having congenital rickets. R5.200.

The only witnesses who offered any testimony that could conceivably rebut this diagnosis—Drs. Nicholas, Janicki, and Fortin—were uninformed and unqualified to do so. Dr. Fortin demonstrated no expertise in either orthopedics, *see supra* fn.4-6, or rickets (erroneously claiming that the relevant indicator is ionized calcium then correcting herself when caught in her mistake and agreeing that it is serum calcium R5.6-7). Her opinions on this topic simply lack any merit. Dr. Janicki has never diagnosed a patient with rickets, does not know the principal cause of rickets, has no formal training in rickets, and has never even heard of congenital rickets. *See* Facts *supra* p.26. Dr. Janicki's only knowledge about the significance of vitamin D comes not from his professional training, but from his *personal experience* as a father. R3.136. Dr. Janicki stated emphatically that he has no expertise in rickets, and he could not dispute another doctor's findings in Yohan of rachitic rosary or craniotabes. *See* Facts *supra* p.26. Dr. Nicholas' testimony was inherently limited

[7] The court erroneously claimed that all of Yohan's levels were normal except for vitamin D. E10.216. The trial court also mistakenly claimed that Yohan's parathyroid hormone was normal, *id.*, when in fact Yohan's parathyroid hormone was never tested. R4.194-96.

as she only viewed the skeletal survey from June 8 and agreed that the sub-quality of those images impaired her ability to fully evaluate the bones. R.210-11. Dr. Nicholas admitted to having no expertise in congenital rickets or in diagnosing rickets in newborn babies. R7.194.

In reaching its conclusion that Yohan had a fracture and did not have rickets, the trial court engaged in a wholly inadequate analysis of the actual evidence. Given the great weight of the evidence countervailing any existence of a fracture, and the significant amount of evidence affirming a diagnosis of congenital rickets, the court's conclusion that Yohan had a fracture caused by abuse was contrary to the manifest weight of the evidence.

2. Yohan Had BEH, a Pre-existing Medical Condition Predisposing Him to Intracranial Bleeding and Retinal Hemorrhaging.

The trial court side-stepped making a determination as to whether Yohan had BEH by leaping to the conclusion that BEH would not be a reasonable explanation for the so-called "constellation" of injuries, E10.217, meaning that because BEH could not account for the alleged fracture, it was disqualified as an explanation for the intracranial and retinal hemorrhages. By skipping the step of determining whether Yohan had a pre-existing medical condition, however, the trial court's reverse-course analysis assumed a connection between the head-related findings and the leg-related findings—a connection that was never proven to exist. Put differently, if the intracranial and retinal hemorrhages can be attributed to BEH, the existence of a separate injury does not change the non-abuse explanation for the head-related findings. The trial court was not free to ignore a central question such as the existence of a predisposing medical condition, or to base its assumptions of the condition's characteristics on the existence of some other injury. The court's failure to make an affirmative finding that Yohan did not have BEH, and its failure to make a

determination that the BEH was an inapplicable causal explanation for Yohan's head-related findings, extinguishes any deference this Court should afford to such conclusions.

The great weight of the evidence establishing that Yohan had BEH is all the more glaring because the doctors who diagnosed BEH are pre-eminent experts in the relevant field, whereas the only doctor who questioned the diagnosis on its own merits (Dr. Burrowes) used an invalid basis for her exclusion, read only a single MRI study, and otherwise lacked expertise in the treatment of this specific condition. As such, the evidence is clear that Yohan K. had the congenital anatomical variant of BEH, and the court was not free to ignore the existence of this predisposing medical condition. Given that the manifest weight of the evidence is clear that Yohan had BEH–and equally clear that a child with BEH is prone to the type of intracranial/retinal hemorrhages Yohan experienced absent inflicted, non-accidental trauma (*i.e.*, due to minimal impact from normal daily activities and/or birth trauma)–the conclusion that Yohan's head injuries were due to abuse is also contrary to the manifest weight of the evidence.

a. *The presence of BEH predisposed Yohan to intracranial bleeding from birth trauma, venous thrombosis, and/or incidental impact.*

Even the State's experts agreed with the Parents' experts on the point most relevant to the question of causation: Drs. Wainwright, R2.150, 242, Burrowes, R8.165, Frim, and Barnes unanimously agreed that infants with BEH are predisposed to intracranial bleeding. As Dr. Frim explained, once a subdural hematoma is present in an infant with BEH, the risk for additional hemorrhaging or re-hemorrhaging, either incidentally or spontaneously, is further increased. R8.26, 31.

Despite having some awareness of the relationship between BEH and intracranial bleeds, none of the CMH doctors considered the existence of BEH as a causative factor at

the time of Yohan's hospitalization or at the time of Dr. Fortin's initial June 2011 report. R2.177-78 (Dr. Wainwright's testimony that to his knowledge, nobody at CMH considered BEH); R4.154-55 (Dr. Fortin's testimony that the first time BEH was raised at CMH was October, 2011). Although Dr. Fortin did not dispute the diagnosis of BEH, she ruled out BEH as a cause for the intracranial bleeding on the basis that she did not think BEH could account for the fracture and retinal hemorrhages. R4.76-77. Clearly, the failure of CMH's doctors to consider BEH as a cause of Yohan's head-related findings was based on lack of expertise in the condition, rather than deliberate consideration of the medical evidence.

Infants with BEH can sustain intracranial bleeds from a variety of non-inflicted causes, two of which in particular—birth trauma, R8.51, and cortical venous thrombosis, R8.187-88—were each plausible explanations for the blood found in Yohan's subdural and subarachnoid spaces. Yohan had a precipitous and complicated birth, *see* Facts *supra* p.5, and he exhibited symptoms consistent with sub-clinical seizures shortly following his birth, including an uncharacteristic refusal to nurse and increased fussiness when he was barely four weeks old. *See* Facts *supra* pp.6-7. Even the State's expert Dr. Wainwright provided undisputed testimony that intracranial bleeding from birth trauma can persist until five weeks of age in infants *without* the complicating effects of BEH, R2.180, 185, and he could not definitively rule out birth-related bleeding in Yohan's case, R2.145. Twenty-five percent of all newborns are born with some form of intracranial bleeding, R2.179, and the posterior location of Yohan's subdural hematomas was more consistent with birth trauma than with non-accidental trauma, R2.183-84.

It is also plausible that Yohan's predisposition to intracranial bleeding was triggered by cortical venous thrombosis. Due to the deficiencies in CMH's diagnostic work-up of Yohan—which did not include a contrast venogram, R8.170-71, did not evaluate for

thrombosis in Yohan's cortical veins, R8.169, and did not include a thrombophilia profile of Yohan's blood, E8.162–it is simply impossible to rule out the presence of venous thrombosis.[8] Moreover, Yohan's vitamin D deficiency predisposed him to venous thrombosis, R5.183, 228, and Dr. Barnes observed on Yohan's June 6 MRI several indicators characteristic for cortical thrombosis. R5.116-17, 183, 228.

Most importantly, however, BEH predisposes infants to sustain bleeds from incidental forces that occur during the activities of daily life, Frim Report, E14.111; R5.159, R2.150, 242, a reality that the court ignored entirely in its ruling. On June 7, Teresa and K.S. described to Dr. Fortin and Investigator Bono several occurrences that provided sufficient explanation for the intracranial bleeding in a child with BEH, including Marika yanking Yohan's hat off his head and Yohan's head falling to the side while sitting in the infant chair. Fortin 2011 Report, E12.186. Given it is undisputed that children with BEH have heightened risk for intracranial bleeding from the *ordinary* forces involved with *daily life*, Dr. Fortin's dismissal of these explanations is further evidence that her opinion cannot be relied upon and shows her rejection of BEH as a causal explanation was unwarranted.

In light of the innumerable plausible and likely medical and incidental triggers for Yohan's intracranial bleeding, a conclusion that the most likely cause was abuse is contrary to the manifest weight of the evidence. Indeed, the only basis the trial court offered for ignoring the BEH explanation was the assumption that the presence of an unrelated injury changed the reliability of the BEH diagnosis and its causal role in Yohan's head-related findings. This assumption was without evidentiary support and was itself an insufficient

[8] Both the ruling of the trial court and the GAL's brief erroneously claim that the anti-coagulation screens ordered by Dr. Mack ruled out clotting disorders. E10.216; GAL Br. 13. This is incorrect. Dr. Mack testified that he was only asked to screen for bleeding disorders, and that clotting disorders would necessitate a separate category of tests. R6.184-85

basis for ignoring the vast weight of evidence establishing a sound medical explanation for Yohan's intracranial bleeding.

b. Yohan's enlarged subarachnoid spaces from BEH account for the retinal hemorrhages.

At trial, Dr. Frim illustrated that blood in the subarachnoid space of an infant with BEH can travel to the optic nerve and retina (which also have enlarged subarachnoid spaces), accumulating in the retina as retinal hemorrhages. R8.27-29; *see also* Frim Diagram, E14.122-23. Even the State's neurologist, Dr. Wainwright, agreed blood in the subarachnoid space of the cranium and cause retinal hemorrhages. R2.190-91. Dr. Frim relied on his own vast experience and knowledge as a pediatric neurosurgeon, including knowledge of the anatomy of the retina related to the subarachnoid space, his own specialized BEH expertise, and the scientific literature.

Dr. Frim described the work of Dr. Joseph Piatt, whose peer-reviewed case study profiled a child with BEH who sustained subdural hematomas and extensive, bilateral, multi-layer retinal hemorrhaging in the absence of abusive trauma. R8.56. Dr. Frim's expert opinion was that the most reasonable and likely explanation for Yohan's retinal hemorrhages was a medical outcome secondary to BEH. R8.72-73. In Yohan's case, it is undisputed that the blood present in his subarachnoid space was traveling, R8.29, 33, and that there was no retinal damage, such as retinoschesis or macular folding. R7.69-70. Based on these facts and the strong opinion of Dr. Frim, a finding that the retinal hemorrhages must have been caused by abuse is contrary to the manifest weight of the evidence.

The weak opinions offered by the only physicians who questioned Dr. Frim's medical explanation, Dr. Fortin and Dr. Yoon, do nothing to undermine the medical explanation. Dr. Fortin's expertise to proffer any opinion in this area is minimal at best,

and certainly insufficient to refute Dr. Frim's well-supported opinion. Dr. Fortin has no specialized training or certification in pediatric neurosurgery or child neurology, and her training in pediatric ophthalmology is limited to a two- or four-week rotation while in medical school. R3.247-R4.2. Dr. Fortin's knowledge about the retinal hemorrhages present in any given case depends entirely upon the description provided by the ophthalmologist, and is, therefore, limited to the quality of that description. R4.118, 120. Due to CMH's failure to follow the AAP's 2007 guidelines requiring photographs or annotated drawings, R4.170-71, R7.54, the quality of the information Dr. Fortin relied upon contains intractable deficits. The written description as provided by Dr. Yoon is itself inherently unreliable and differs significantly from the descriptions provided by all the other ophthalmologists. Facts *supra* p.22.

Drs. Fortin and Yoon's opinions were themselves vague and equivocal. Dr. Fortin claimed that she ruled out medical explanations for the retinal hemorrhages, but failed to specify which conditions were given consideration in Yohan's case. R4.57-58. She claimed that Yohan's retinal hemorrhages were consistent with an "a/d" force R4.58, but did not describe what that meant or on what authority she was basing this conclusion. She then changed course and stated she was *not* providing an opinion as to what mechanism caused the retinal hemorrhaging, R4.204-06. Dr. Yoon's trial testimony was even more erratic, and certain portions were struck by the court for deviating from his sworn deposition testimony. R6.248-R7.2. Nonetheless, Dr. Yoon confirmed that the cause of retinal hemorrhages cannot be deduced from the type, location, shape, or appearance of the hemorrhages, R7.72, 76, 118, and that intracranial bleeding can cause retinal hemorrhages, R7.77. Dr. Yoon was in no position to dispute or undermine the opinion of Dr. Frim given that he had virtually no familiarity with BEH and did not know what impact BEH would have on

blood in the retinal space. R7.39-41. Finally, neither Dr. Yoon nor Dr. Fortin could identify any difference between the retinal hemorrhaging present in Yohan and the retinal findings in Dr. Piatt's case study. R4.177-80, R7.113-14, 126.

3. The Expert Medical Opinions, When Evaluated Properly, Do Not Sustain a Finding of Abusive Causation.

Though it is the province of the trier of fact to assess the credibility of expert witnesses when they reach different conclusions, there is an expectation that the conflict will be resolved by evaluating the relative merits of the experts and their opinions. *LaSalle Bank, N.A. v. C/HCA Dev't Corp.*, 384 Ill. App. 3d 806, 828 (1st Dist. 2008). An expert's opinion cannot be based upon mere speculation, supposition, or possibility, and the opinion is only as valid as the reasons for the opinion. *Soto v. Gaytan*, 313 Ill. App. 3d 137, 146-47 (2d Dist. 2000). Examination of the trial court's ruling reveals, however, that the court below failed to engage in a meaningful evaluation of the experts' credibility or the relative quality and strength of their opinions. The Parents' experts offered medically certain non-abuse explanations as to areas of medicine in which they are each eminent and renowned experts. The physicians testifying for the State as to an "inflicted trauma" theory, in contrast, speculated about the *possible* mechanisms causing the alleged injuries, *see* supra pp.55-58, and were sorely lacking in the relevant areas of expertise.

It is notable that all of the physicians claiming to have ruled out medical explanations for Yohan's symptoms—Drs. Wainwright, Yoon, Fortin, and Janicki—are affiliated with the very institution CMH, that failed to conduct a contrast venogram, R8.170-71, failed to check for thrombosis in the cortical veins, R8.169, failed to perform a thrombophilia blood work-up, E8.162, failed to take photographs of the retinas, R7.50-52, failed to test for a vitamin D deficiency, R4.188-91, and failed to screen for an elevation in

parathyroid hormone, R4.194-96. Based on such an objectively deficient evaluation, it is puzzling how those doctors were then able to rule out plausible medical explanations. Furthermore, the CMH physicians testifying for the State and the GAL offered testimony that deviated from their deposition testimony, was internally inconsistent, and was beyond the scopes of their expertise.

The single critique the court offered as to any of the experts—faulting Dr. Frim for not considering a potential fracture when making a neurosurgical diagnosis—is indicative not of a deficiency in Dr. Frim's opinion but of the error in logic undergirding the court's entire ruling. The court's unsubstantiated assumption that there *must have been* a connection between Yohan's head-related findings and the suspected fracture to his femur has no basis in evidence, law, or reason. The trial court's dismissal of Dr. Frim's opinion, therefore, was improper and its expectation that the Parents' experts acknowledge a link between the bone findings and the intracranial/retinal findings failed to recognize the superior credentials and highly-specialized expertise of Drs. Frim, Barnes, and Sullivan.

B. The Law Does Not Permit a Court to Make a Finding of Abuse Absent Some Evidence of an Abusive Action Toward the Child.

The Juvenile Court Act defines child abuse as occurring when a person responsible for the minor's welfare "inflicts, causes to be inflicted, or allows to be inflicted upon such minor physical injury, by other than accidental means." 705 ILCS 405/2-3. In this case, there was no evidence submitted at the adjudicatory hearing that any of Yohan's presumed injuries were caused by non-accidentally inflicted trauma. *See supra* pp.55-56. For this reason alone, the trial court's finding of abuse was legally erroneous. Additionally, it is apparent from the ruling that the trial court did not think there was evidence that Yohan's only caretakers—Teresa G. and K.S.—had perpetrated any abuse. As addressed *infra*,

pp.71-72, the trial court was "unable . . . to determine from the evidence who the perpetrator of this abuse was." E10.217. This inability derived directly from the court's finding that Yohan's only caretakers, Teresa G. and K.S., were:

> [L]oving and responsible parents. They spend as much time as they can with both of their children and have done so since the births of Marika and Yohan. They nurture them, play with them, read to them, and care for them in every way. One or both of the parents have attended every medical appointment. Marika, who was more than 2 ½ years old when this case came in, has never had any issues or problems with her care. Prior to June of 2011, the same can be said for Yohan. E10.215.

These findings were based not only on the evidence of their exemplary parenting provided by the witnesses, but upon the trial court's own observations of Teresa G. and K.S. as parents during the many days of proceedings at which Yohan was present.

The Parents have already explained the court's incorrect assumptions about the "constellation of injuries." The "constellation of parents" (*i.e.*, more than one) allowed him to reach an abuse conclusion without finding an abuser. Insight into why the trial court felt pressed to make findings of abuse despite its clear conviction that neither of Yohan's parents was a likely perpetrator of abuse, and there was no identification of an abusive action causing Yohan's injuries, may be found in comments the court made before the adjudicatory hearing: "if [Yohan's condition being the result of inflicted abuse] is not the case, then the parents have been horribly mistreated . . . . If they did not abuse their children, then they have been mistreated in this case, and there's no doubt about it." R2.20. Dismissing the State's Petitions would have effectively acknowledged that the allegations of abuse were misplaced and that these "loving and responsible" parents had, indeed, been horribly mistreated. The trial court's inability to identify a perpetrator strongly suggests that the finding of abuse by a "person responsible" for the children cannot be sustained as nothing in the voluminous record points to either Teresa or K.S. as a suspect for abuse, let

alone as person who would inflict an injury on their son, and there existed no evidence whatsoever of a non-accidental injury.

III. CONTRARY TO THE CONTENTION OF THE GAL, THE LAW DOES NOT REQUIRE THE TRIAL COURT TO IDENTIFY A PERPETRATOR OF ABUSE WHEN IT IS UNABLE TO DO SO.

While acknowledging that upon a finding of abuse, the Juvenile Court Act merely requires the trial court to "specify, ***to the extent possible***, the acts or omissions or both of each parent, guardian, or legal custodian that form the basis of the court's finding," 705 ILCS 405/2-20 (emphasis supplied), the GAL nonetheless contends that the court in *this* case was subject to a special obligation to identify the perpetrator(s) despite no obligation being contained in the statute. GAL Br. 33, 37. In making this claim, however, the GAL fails to identify any legal authority establishing such an obligation.

The two cases cited by the GAL, *In re J.B.*, 332 Ill. App. 3d 316 (1st Dist. 2002) and *In re A.M.*, 296 Ill. App. 3d 752 (1st Dist. 1998), are clearly inapposite to a situation in which a court has been unable to identify a perpetrator. In *J.B.*, this Court held the trial court had not abused its discretion by naming the father of J.B.'s half-sibling as the perpetrator of J.B.'s sexual abuse. *J.B.*, 332 Ill. App. 3d at 321. In *A.M.*, this Court held that the trial court had not abused its discretion when it declined to identify a non-party as the perpetrator of abuse. *A.M.*, 296 Ill. App. 3d at 757. The GAL cited no case supporting the proposition that a trial court's inability to identify a perpetrator can be deemed an abuse of discretion. The absence of such case law is consistent with the plain language of the statute creating no obligation to identify a perpetrator.

The GAL attempts to buttress its claim by arguing that "[t]he preponderance of the evidence overwhelmingly favors naming Teresa G. and/or K.S. as perpetrators of abuse." GAL Br. 36. Even if true, however, this claim does nothing to advance the GAL's position.

The statute directs the court to identify, if able, the acts or omissions "of each" parent, providing no support for the type of plurality identification suggested by the GAL here. Moreover, the existence of a "preponderance" of the evidence is insufficient for this Court to hold that the lower court abused its discretion, for an "abuse of discretion" finding requires a ruling that is arbitrary and unreasonable. *In re Alexis H.*, 401 Ill. App. 3d 543, 560 (1st Dist. 2010). Finally, the GAL's claim that "the best interests of Marika and Yohan require the identification of a perpetrator," GAL Br. 36, rings hollow in the absence of any reference to or application of the statute's best interests factors, 705 ILCS 405/1-3(4.05). Moreover, even if it were in the bests interests of the children to identify an abuser, that would not overcome the absence of evidence enabling a court to make such a determination. Indeed, the GAL is equally unable to point to an abuser. For these reasons, the GAL is unable to establish that the trial court abused its discretion in not identifying a perpetrator and not specifying either parent as a perpetrator.

IV. THE RECORD AMPLY SUPPORTS THE TRIAL COURT'S FINDINGS THAT THE PARENTS ARE "FIT, WILLING, AND ABLE" TO CARE FOR THEIR CHILDREN AND THAT IT WAS (AND IS) IN THE CHILDREN'S BEST INTERESTS TO RETURN HOME.

The GAL asserts that the final dispositional order returning the children home under an Order of Protective Supervision is contrary to the manifest weight of the evidence because the parents allegedly failed to engage in "meaningful therapy." GAL Br. at 44, *citing In re M.W.*, 386 Ill. 3d 186, 195 (1st Dist. 2008). On that basis alone, he requests that this Court overturn the juvenile court's findings that the parents are "able" to care for the children and that it was in the children's best interests to be returned to their care. He further asks that this Court direct that the children be taken from their parents once again so that DCFS can return them to some unspecified form of alternative care.

The GAL acknowledges that the juvenile court's dispositional orders are entitled to great deference, GAL Br. 37-38. He does not dispute that the Parents were compliant and completed all of the service requests of DCFS, including the therapy requirements. *Id.* at 41. He does not claim that the Parents' therapists, Drs. Helen and Robert Evans (who hold Ph.Ds. in clinical psychology and social work, respectively, and who each have 30-40 years of experience, Facts *supra* pp.45, 48) lack expertise in assessing, evaluating, and treating DCFS-involved families. Nor does the GAL dispute that Yohan and Marika respond well to their parents' care, or claim that there have been any incidents of concern regarding maltreatment of the children since the contested incidents giving rise to the filing of the Petitions for Adjudication of Wardship.

In the context of this case, the GAL's attacks on the juvenile court's findings are particularly misplaced. Unlike the difficulty the trial court experienced in assessing the complex medical evidence before it in the adjudicatory hearing, E10.215, the trial court did not so much as hint that the record at the dispositional hearing presented any close call. That ruling was based on the testimony of three witnesses (two expert therapists and the DCFS caseworker), numerous prior assessments and reports, the favorable DCFS recommendations, and the court's own observations of the Parents over a period of fifteen months of legal proceedings. Indeed, while the GAL assails the findings of the juvenile court that the Parents' therapy was not "meaningful" or "effective," not a single bit of evidence supports the GAL's position that the children should not be returned to their parents due to this alleged deficit in the therapy. Moreover, the GAL presented no evidence supporting the conclusion that "meaningful therapy" cannot and did not occur here due to the Parents' steadfast assertions of their innocence of the abuse allegations.

Despite the lack of evidentiary support for the GAL's position, the GAL insists that the Parents must "acknowledge their child Yohan is abused." GAL Br. at 41-42 (stating that "by failing to acknowledge that Yohan was a victim of abuse the non-perpetrating parent cannot fully protect Yohan from the perpetrating parent," citing no authority in support of this proposition). Even more troubling than the lack of evidentiary support for his position is the GAL's apparent lack of concern with the implications his own position has as to the unassailable legal right of the Parents to maintain their innocence throughout an appellate process, and to contest the adjudicatory hearing finding of abuse by means of a cross-appeal here. Application of the GAL's "acknowledge the abuse" position would require the Parents to forfeit their appeal rights in order to secure return of their children.

Nor does it seem to trouble the GAL that his position has some dramatic implications for other fundamental constitutional rights the Parents possess, beyond the right to appeal the juvenile court's abuse finding. The GAL insists that the Parents need to change their thoughts or opinions about the causes underlying their son's medical findings. GAL Br. 42 (the "therapists cannot fully assist the non-perpetrating parent with strategies to protect Yohan from future abuse when the parents are ***in denial*** that the abuse occurred" (emphasis supplied)). That the Parents' beliefs about their child's medical history are consistent with the opinions of three leading medical specialists at preeminent university hospitals does not give the GAL any pause in referring to them as "in denial" such that they need to change their views in order to have their family life restored. But parents have fundamental First, Ninth and Fourteenth Amendment rights to hold beliefs about their children's medical conditions, to agree with certain experts and disagree with others, and to share their beliefs by expressing them to service providers and in a courtroom. U.S. Const. amend. 1; *see, e.g., Brandenburg v. Ohio*, 395 U.S. 444 (1969) (holding that a person's

speech may only be restricted if it is "directed to inciting or producing imminent lawless action, and is likely to incite or produce such action"); *Moore v. City of East Cleveland*, 431 U.S. 494, 499 (1977) (citing litany of cases on family integrity and privacy protected by the Constitution).

To insist that the Parents must "acknowledge" or acquiesce to the truth of a trial court's non-final findings of fact in order to be deemed to have had "meaningful therapy" smacks of a more totalitarian approach to mind-control than an accepted precept of the Illinois or American legal system. It would be more than a little unfortunate were this Court to hold that these college-educated, immigrant parents, who came to the United States believing "it's the land of opportunity. The land of justice, freedom and justice," R9.224, and who are deeply religious, Facts *supra* pp.40-41, should be declared "unable" to care for their children due solely to their persistent belief in their own innocence of wrongdoing.

Fortunately, there is no support in the Juvenile Court Act, *see* 705 ILCS 405/1-1 and 1-3(4.05) (defining best interests factors), the rules governing DCFS, or Illinois jurisprudence to support the GAL's contention that an acknowledgement of abuse is a *per se* requirement for therapy to be considered meaningful. Indeed, the GAL's position that the Parents can be deemed "unable" to care for their children as a result of not having engaged in "meaningful therapy" is predicated on a misreading of case law in which parents failed to make actual progress in therapy. To be sure, where there has been an adjudication of abuse or neglect, more than rote compliance with a service plan is required. However, the cases the GAL cites as illustrative of its "acknowledge the abuse" requirement actually support the conclusion that the Parents in this case, Teresa and K.S., have more than met the minimum requisite showing as to their parenting abilities and progress in therapy.

The GAL first cites *In re M.W.*, 386 Ill. App. 3d at 186, for the requirement that a parent must show sufficient progress in therapy. In *M.W.*, it was undisputed that the mother's older child D.J. had multiple severe and observable injuries, that the mother Lori B. gave false explanations for the injuries and lied to the police, that her paramour had pled guilty to aggravated battery for burning the child and inserting a plunger into his rectum, and that D.J. had been diagnosed as a battered child and a victim of child sex abuse, repetitive child physical abuse, and medical neglect. *Id.* at 187-89. Moreover, the mother had a mental health diagnosis that "cast doubt on her ability to become an independent, self-functioning person" who did not "repeat a pattern of selecting an abusive partner and prioritiz[ing] that relationship above protecting her child." *Id.* A psychological evaluation recommended that she have two to three years of therapy. *Id.* A later report found she had "limited awareness of the dynamics of the relationship with D.J.'s abuser" and that "due to the deeply rooted nature of her vulnerability and anxiety concerning her own childhood," she might not make sufficient timely progress in therapy to meet M.W.'s needs. *Id.* at 193. Her attendance in therapy at the time of the dispositional hearing was inconsistent. *Id.* at 194.

The appellate court in M.W. overturned the trial court's finding that Lori B. had made sufficient progress and was "able" to care for her children for several reasons: she was still being assessed for domestic violence services, she had just been referred to a more experienced therapist, the evaluations the court received stated she needed to "fully deal with her own history of trauma," and that she had a personality disorder. *Id.* at 199.

The differences between the Parents in this case and the mother in *M.W.* could not be more stark. In just about every respect, Teresa and K.S. have demonstrated they have fulfilled all the reasonable expectations one can have for parents. There is no history of

prior mistreatment of any child. They acted promptly to care for the children. They accepted services willingly and cooperated fully. They had no assessed mental illnesses or mental deficiencies. They had not lied to anyone. They completed all tasks set before them. They behaved in a calm and patient manner with their children and they demonstrated ability to provide consistent responsible care for them. And unlike all the cases cited by the GAL, their own therapists considered their therapy meaningful, effective, and complete.

Other cases the GAL cites for the proposition that the Parents' therapy was not meaningful due to a failure to acknowledge Yohan was abused actually stand for no such thing. In *In re L.F.*, 306 Ill. App. 3d 748 (3rd Dist. 1999), the appellate court expressly held that mother/foster mother Loreaca F.'s Fifth Amendment rights were violated by an order that required her to admit she was responsible for causing her ward's death. In that case, Loreaca's biological children told police that Loreaca had slapped and "whupped" the ward on the day he died because he "pooped on himself." *Id.* at 750. There were also 22 separate incidents of scarring on the child's body. *Id.* The court adjudicated Loreaca F. responsible for excessive corporal punishment and concluded the child had died at her hands. *Id.* The report the court received included a psychological finding of a "high level of maladjustment." *Id.* at 751. Loreana F. appealed a permanency goal of termination of parental rights, challenging the DCFS service plan that stated she must "acknowledge responsibility for the maltreatment of the child in her care." *Id.*

The appellate court concluded that there is a "very fine but important distinction" between terminating a parent's rights based on a refusal to waive a right against self-incrimination and doing so based on a parent's failure to comply with an order for meaningful therapy. *Id.* at 753 (citations omitted). While it recognized that therapy without

"incriminating disclosure may be ineffective" and may "hurt the respondent's chances of regaining her children," this holding was an observation about the therapeutic process, not a legal rule that disclosures are an essential prerequisite for "effective" therapy. Indeed, the appellate court held that requiring a specific admission violated the mother's rights under the Fifth Amendment, and it remanded the case for a new permanency hearing without considering whether the evidence of lack of progress toward return home was contrary to the manifest weight of the evidence.

L.F. was adopted and its application clarified by the Illinois Supreme Court in *In re A.W.*, 231 Ill. 2d 92 (2008). In that case, the father, Eugene, had been previously indicated twice for sexual abuse of A.W.'s sibling, and both he and A.W.'s mother had previously been adjudicated unfit, findings that had been affirmed on appeal. *Id.* at 97. In the sibling's case, Eugene had been ordered to complete sex offender counseling. In the adjudicatory hearing concerning A.W., Eugene was barred from contesting the sexual abuse findings as to her sibling and the juvenile court found that Eugene had not "overcome the finding of unfitness" that arose from the sibling's case. At the dispositional hearing, the juvenile court (unlike here) found that the father had made "minimal progress because [inter alia] he failed to attend regularly . . . and had been discharged for 'being uncooperative.' He had been encouraged to return to therapy even if he did not admit any sexual offenses." *Id.* at 98. The Illinois Supreme Court held that Eugene was barred by collateral estoppel from refuting the prior sexual abuse determination and it upheld the neglect and unfitness findings as to A.W. *Id.* at 102-05. Eugene asserted the discharge from sex offender therapy for his refusal to admit his past [adjudicated and affirmed] offenses violated his Fifth Amendment rights. *Id.* at 105.

Reviewing and affirming the holding of *L.F.*, the Illinois Supreme Court in *A.W.* affirmed that a trial court may order effective therapy but may not compel counseling or therapy that requires a parent to admit to committing a crime. *Id.* at 106-107. The Court noted that the father in *A.W.*, however, had not established the absence of treatment programs not requiring an admission of abuse. Given that there was ample support in the evidentiary record for the conclusion that Eugene had not received therapy *any* professional would endorse as "meaningful" or effective, the Illinois Supreme Court's decision in *A.W.* reinforces that conclusion that even for an court-identified perpetrator of abuse, who had been found "unfit" in a related case, there is no *per se* rule that an admission or acknowledgement of abuse is necessary for therapy to be deemed "meaningful" or "effective." Rather, the determination of whether therapy has been sufficient turns on the specific evidence as to the parents' progress in therapy, as reported by their treating professionals, and the totality of the other evidence before the trial court.

CONCLUSION

For all of the foregoing reasons, Parents-Appellees/Cross-Appellants respectfully request that this Court enter an order reversing the finding of the lower court that Yohan and Marika were abused and neglected and remanding the case for immediate dismissal. In the alternative, Parents-Appellees/Cross-Appellants request that this Court enter an order finding that the lower court's inability to identify a perpetrator was not an abuse of its discretion and that the lower court's finding that the Parents were fit, willing, and able to care for their children was not contrary to the manifest weight of the evidence.

Respectfully submitted,

TERESA G. and K.S.

By: _____

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Respectfully submitted,

TERESA G. and K.S.

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Dated: April 23, 2013

CERTIFICATE OF COMPLIANCE

I, Melissa L. Staas, hereby certify that the foregoing **Brief and Appendix of Parents-Appellees and Cross-Appellants** conforms to the requirements of Supreme Court Rules 341(a) and (b). The length of this brief, excluding the pages containing the Rule 341(d) cover, the Rule 341(h)(1) statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a), is **80 pages**.

Melissa L. Staas

TABLE OF CONTENTS TO THE APPENDIX

Court's Exhibit 1
K[redacted] 11JA512-3
August 1, 2012

#5

Adjudication Ruling

This has been an extremely difficult case for me to decide. Besides the civilian witnesses, I have heard testimony from eleven expert medical witnesses from various specialties. I listened to their testimony and took notes. I have reviewed those notes and also read the transcripts of each of the eleven expert witnesses. I made notes again as I read those transcripts. I have re-read those notes a number of times before arriving at a decision. I have carefully considered all arguments of counsel, each of whom has done an incredible amount of excellent work in this case. And I have made a decision based on the evidence which I will explain at this time.

According to the evidence, mother and father are loving and responsible parents. They spend as much time as they can with both of their children and have done so since the births of Marika and Yohan. They nurture them, play with them, read to them, and care for them in every way. One or both of the parents have attended every medical appointment. Marika, who was more than 2 ½ years old when this case came in, has never had any issues or problems with her care. Prior to June of 2011, the same can be said for Yohan.

On June 5, 2011, Yohan was five weeks old. His parents called their pediatrician when Yohan vomited after acting unusually fussy and irritable that day. They reported and testified that Yohan previously experienced staring episodes and incidents of a high pitched scream. A pediatrician told them over the phone not to go to the emergency room unless certain symptoms occurred which apparently did not. However the parents made an appointment with their pediatrician for the next morning and brought Yohan in at that time. He was having clinical seizures and was immediately taken to the emergency room at Children's Memorial Hospital, where he was examined and treated. He was given medication to control the seizures. CT scans, MRI's and x-rays were taken. Various tests were run.

To summarize the State and GAL's evidence, Yohan was diagnosed with what I would characterize as three separate injuries. 1) a left distal femur metaphyseal corner fracture; 2) subdural and intracranial bleeding with ischemia to both sides of his brain resulting in seizures; and 3) bilateral retinal hemorrhages, too many to count. The opinion of the State and GAL's expert witnesses, those of which had an opinion, was that these injuries were most likely caused by non-accidental inflicted trauma. 4444

The parents presented the testimony of four of their own medical experts, who, in summary, opined as follows: 1) that there was no fracture of the left knee, but that the imaging studies were most consistent with a condition called rickets, 2) that the bleeding in the minor's brain was consistent with a condition called benign external hydrocephalus (BEH) and said bleeding was likely triggered by birth trauma, 3) that the retinal hemorrhages could be explained absent inflicted trauma in that the bleeding caused by the birth trauma moved into the eyes, which are

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connected to the brain. Further, that seizures can result by this blood irritating the surface of the brain. Three of the experts called by the parents were of the opinion, therefore, that Yohan did not suffer inflicted trauma, but that he suffered from various medical conditions.

In my opinion, the most critical determination in this case revolves around the minor's left knee. Drs. Janicki, Nicholas and Fortin diagnosed the minor with a fracture. Drs. Sullivan and Barnes testified that they saw no evidence of fracture, but that the imaging evidence was consistent with rickets. In analyzing these two positions, all parties agree that the existence of periosteal reaction in a later x-ray would be evidence of healing that would confirm the diagnosis of a fracture. In looking at the same imaging studies, the former group found periosteal reaction in the June 23rd imaging, while the latter two did not. Both sides agreed that rickets would display on an imaging study as a bowed or cupping or fraying appearance at the ends of the bones. Dr. Nicholas did not find that on the imaging she reviewed, while Dr. Barnes did. Testimony regarding whether a fracture of this type in an infant this young would cause noticeable pain also differed between experts.

However, one thing that the sides did agree on was that the condition of rickets could be confirmed or diagnosed through a series of blood tests, including alkaline phosphate, calcium, phosphorus and parathyroid hormone tests. Some of these confirmatory blood tests were done at Children's Memorial and the results were in the normal range, which indicates that the minor did not have the condition. No test result confirmed a diagnosis of rickets. Yohan's vitamin D level was found to be low, which the parents argued was an indication of rickets. However, a low vitamin D level has been found to be common in breast fed babies, which Yohan was, and is not, in and of itself, diagnostic of rickets. Accordingly, I find that the evidence has proven that Yohan K[redacted] suffered a fracture of the left distal femur and did not have the medical condition of rickets. I further find that said fracture has not been explained in any manner consistent with accident and as such must have been an inflicted non-accidental injury.

Moving on to the issues surrounding the blood in the minor's brain and the retinal hemorrhages, the parents' expert witnesses have offered opinions that these findings are consistent with medical causes more likely than injuries that were the result of non-accidental trauma. The testimony of Dr. Mack is quite compelling in that regard. As an expert in pediatric hematology, he testified to the following tests performed to determine whether there was a plausible bleeding abnormality which could explain the constellation of findings in this case: complete blood count; coagulation factors; factors 7, 8, 9 and 11; platelet function analysis; thrombin time test; fibrogin level. All results were normal. His conclusions were that the minor did not suffer from any clotting disorder or bleeding disorder. He found no hematological reason for bleeding in Yohan's brain.

Dr. Frim, in support of his opinion that the minor's condition was more likely caused by a precipitous delivery which caused bleeding to an infant with BEH, testified that the existence of

fracture or trauma elsewhere on the system was not relevant to his diagnosis. The court agrees with the expert witnesses called by the State and the GAL that evidence of trauma elsewhere on the body of this infant is very relevant. It is the so-called "constellation of findings" in this case that is most indicative of abuse. The parents have offered separate non-abuse explanations for the series of conditions found to exist in Yohan K[redacted] on June 6, 2011.

Perhaps one could be persuaded that birth trauma and BEH are responsible for Yohan's intracranial bleeding, without any other medical findings. Perhaps one could be persuaded that blood from a benign bleed flowed into the minor's eyes, causing retinal hemorrhages too many to count five weeks after birth, without any other medical findings. Perhaps one could be persuaded that despite the existence of blood tests non-indicative of rickets, that the imaging is unclear enough as to whether periosteal reaction exists to prevent the finding of a fracture, absent any other medical findings. But for the court to conclude that all three of these infrequent to rare conditions came together at the same time to explain this minor's condition is not reasonable. It is, therefore, more likely than not that Yohan K[redacted] suffered non-accidental inflicted trauma in this case.

Which leads me to conclude that the State has proven by a preponderance of the evidence that Yohan K[redacted] suffered physical abuse. Accordingly the State has also proven neglect injurious environment and abuse substantial risk of injury as to both Yohan and Marika, who suffered no abuse or injury.

I am unable, however, to determine from the evidence who the perpetrator of this abuse was. Therefore, I make no finding as to a perpetrator.

STATE OF ILLINOIS }
COUNTY OF COOK } ss:

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☒ 4600

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
DEPARTMENT OF JUVENILE JUSTICE AND CHILD PROTECTION
CHILD PROTECTION DIVISION

IN THE INTEREST OF

Marika K[redacted] } No. 11JA512

Minor(s)

ADJUDICATION ORDER
(705 ILCS 405/2-21)

This cause, coming to be heard on the Petition for the Adjudication of Wardship alleging the above named minor is abused, neglected, or dependent. The Court, having jurisdiction of the matter and parties, having heard evidence, and being fully advised in the premises, FINDS that the minor is:

7219 ☐ 1. not abused, neglected, or dependent as defined in 405/2-3 or 405/2-4 of the Juvenile Court Act.

☒ 7119 2. abused or neglected as defined in 405/2-3 of the Juvenile Court Act in that conduct toward the minor violates:

- 7109 ☐ 405/2-3(1)(a) lack of care
- 7110 ☒ 405/2-3(1)(b) injurious environment
- 7111 ☐ 405/2-3(1)(c) drug exposed infant
- 7141 ☐ 405/2-3(1)(d) minor, under age 14, left without supervision for an unreasonable period of time
- 7112 ☐ 405/2-3(2)(i) physical abuse
- 7113 ☒ 405/2-3(2)(ii) substantial risk/physical injury
- 7114 ☐ 405/2-3(2)(iii) sexual abuse
- 7115 ☐ 405/2-3(2)(iv) torture
- 7116 ☐ 405/2-3(2)(v) excessive corporal punishment

ENTERED
JUDGE BERNARD J. SARLEY-2023
AUG 01 2012
DOROTHY BROWN
CLERK OF THE CIRCUIT COURT
OF COOK COUNTY, IL
DEPUTY CLERK

because See admitted courts exhibit #1 entered August 1, 2012 and attached here-to

and the abuse or neglect of the minor

☐ is not the result of abuse or neglect inflicted by a parent, guardian, or legal custodian of the minor.

-OR-

☐ is the result of abuse or neglect inflicted by a:

☐ 7148 parent ☐ 7149 guardian ☐ 7150 legal custodian of the minor

☐ 7147 3. dependent as defined in Section 405/2-4 of the Juvenile Court Act because the minor is under 18 and:

☐ 7120 a. is without a parent, guardian, or legal custodian; or

☐ 7121 b. is without proper care because of the physical or mental disability of the parent, guardian, or custodian;

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No. 11 JA 512

7122 ☐ c. is without proper medical or other remedial care recognized under State law or other care necessary for his or her well being through no fault, neglect, or lack of concern by his/her parents, guardian or custodian;

7123 ☐ d. has a parent, guardian, or legal custodian who with good cause wishes to be relieved of all residual parental rights and responsibilities, guardianship, or custody, and who desires the appointment of a guardian of the person with power to consent to the adoption of the minor under Section 2-29.

7140 ☐ e. findings reserved pursuant to 405/2-20.

IT IS HEREBY ORDERED that:

☐ 8001 A. The petition is dismissed; or

☒ B. The dispositional hearing will be held

☐ instanter;

☐ 4790 ☒ before this Court on 8/20, 2012, at 9:30 (a.m./p.m.)

☐ 4119 C. An investigation shall be made and a report prepared by _____ and submitted to this Court on or before _____ detailing the minor's physical and mental history, family situation and background, and other helpful information.

☐ D. The 2-25 Order of Protection entered against _____ on _____, _____, is incorporated herein.

☒ E. The statutory requirement to hold the dispositional hearing within thirty days is waived with the consent of all the parties.

☒ F. Case is set for hearing on 8/20, 2012, at 9:30 (a.m./p.m.) for:

4290 ☐ Progress Report 4590 ☐ Permanency Hearing 4691 ☐ Judicial Determination

4390 ☒ Status 4359 ☐ Completion of Adoption 4490 ☐ Other _____

4890 ☐ Termination 4790 ☐ Disposition

Before the: 4391 ☒ Judge 4392 ☐ Hearing Officer

DATED: 8.1.12 ENTERED: _____ 2023

JUDGE JUDGE'S NO.

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DOROTHY BROWN, CLERK OF THE CIRCUIT OF COOK COUNTY, ILLINOIS

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STATE OF ILLINOIS }ss:
COUNTY OF COOK }

4600

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
DEPARTMENT OF JUVENILE JUSTICE AND CHILD PROTECTION
CHILD PROTECTION DIVISION

IN THE INTEREST OF

Yohan K[redacted] Minor(s)

No. 11JA513

ADJUDICATION ORDER
(705 ILCS 405/2-21)

This cause, coming to be heard on the Petition for the Adjudication of Wardship alleging the above named minor is abused, neglected, or dependent. The Court, having jurisdiction of the matter and parties, having heard evidence, and being fully advised in the premises, FINDS that the minor is:

7219 ☐ 1. not abused, neglected, or dependent as defined in 405/2-3 or 405/2-4 of the Juvenile Court Act.

ENTERED
JUDGE BERNARD J. SARLEY-2023
AUG 01 2012
DOROTHY BROWN
CLERK OF THE CIRCUIT COURT
OF COOK COUNTY, IL
DEPUTY CLERK

☒ 7119 2. abused or neglected as defined in 405/2-3 of the Juvenile Court Act in that conduct toward the minor violates:

- 7109 ☐ 405/2-3(1)(a) lack of care
- 7110 ☒ 405/2-3(1)(b) injurious environment
- 7111 ☐ 405/2-3(1)(c) drug exposed infant
- 7141 ☐ 405/2-3(1)(d) minor, under age 14, left without supervision for an unreasonable period of time
- 7112 ☒ 405/2-3(2)(i) physical abuse
- 7113 ☒ 405/2-3(2)(ii) substantial risk/physical injury
- 7114 ☐ 405/2-3(2)(iii) sexual abuse
- 7115 ☐ 405/2-3(2)(iv) torture
- 7116 ☐ 405/2-3(2)(v) excessive corporal punishment

because See admitted courts exhibit #1 entered august 1, 2012 and attached hereto

and the abuse or neglect of the minor

☐ is not the result of abuse or neglect inflicted by a parent, guardian, or legal custodian of the minor.

-OR-

☐ is the result of abuse or neglect inflicted by a:

☐ 7148 parent ☐ 7149 guardian ☐ 7150 legal custodian of the minor

☐ 7147 3. dependent as defined in Section 405/2-4 of the Juvenile Court Act because the minor is under 18 and:

☐ 7120 a. is without a parent, guardian, or legal custodian; or

☐ 7121 b. is without proper care because of the physical or mental disability of the parent, guardian, or custodian;

No. 11 JA 513

7122 ☐ c. is without proper medical or other remedial care recognized under State law or other care necessary for his or her well being through no fault, neglect, or lack of concern by his/her parents, guardian or custodian;

7123 ☐ d. has a parent, guardian, or legal custodian who with good cause wishes to be relieved of all residual parental rights and responsibilities, guardianship, or custody, and who desires the appointment of a guardian of the person with power to consent to the adoption of the minor under Section 2-29.

7140 ☐ e. findings reserved pursuant to 405/2-20.

IT IS HEREBY ORDERED that:

☐ 8001 A. The petition is dismissed; or

☒ B. The dispositional hearing will be held

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☐ 4790 ☒ before this Court on 8/20, 2012, at 9:30 (a.m.)/p.m.

☐ 4139 C. An investigation shall be made and a report prepared by _____ and submitted to this Court on or before _____ detailing the minor's physical and mental history, family situation and background, and other helpful information.

☐ D. The 2-25 Order of Protection entered against _____ on _____, _____, is incorporated herein.

☒ E. The statutory requirement to hold the dispositional hearing within thirty days is waived with the consent of all the parties.

☒ F. Case is set for hearing on 8/20, 2012, at 9:30 (a.m.)/p.m. for:

4290 ☐ Progress Report 4590 ☐ Permanency Hearing 4691 ☐ Judicial Determination

4390 ☒ Status 4359 ☐ Completion of Adoption 4490 ☐ Other _____

4890 ☐ Termination 4790 ☐ Disposition

Before the: 4391 ☒ Judge 4392 ☐ Hearing Officer

DATED: 8.1.12 ENTERED: _____ 2023

A7 JUDGE JUDGE'S NO.

THIS CROSS APPEAL INVOLVES A QUESTION OF CHILD CUSTODY, ADOPTION, TERMINATION OF PARENTAL RIGHTS, OR OTHER MATTERS AFFECTING THE BEST INTERESTS OF A CHILD
No. 1-12-3472

CROSS APPEAL TO THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

FROM THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
JUVENILE JUSTICE & CHILD PROTECTION DEPARTMENT
CHILD PROTECTION DIVISION

In the Interest of: Marika K[redacted] & Yohan K[redacted], Minors-Respondents-Appellants,	)	
(People of the State of Illinois, Petitioner,	)	No. 11 JA 512, 11 JA 513
v.	)	
K[redacted] S[redacted], Father-Respondent-Appellee, Cross Appellant,	)	Judge Bernard Sarley 91
Teresa G[redacted], Mother-Respondent-Appellee, Cross Appellant)	)	

NOTICE OF CROSS APPEAL

Father-Respondent-Appellee, Cross Appellant, K[redacted] S[redacted], cross appeals to the Appellate Court of Illinois for the First District from the following order entered in the Circuit Court of Cook County, Child Protection Division:

1. Court to which appeal is taken: Appellate Court of Illinois, First Judicial District.

2. Name of appellant , address, and telephone number to which notices shall be sent:

K[redacted] S[redacted]
C/o Ellen Domph
53 W. Jackson Blvd.
Suite 1544
Chicago, IL 60604
312-922-2525

3. Name, address, and telephone number of trial attorney:
   Ellen Domph
   53 W. Jackson Blvd.
   Suite 1544
   Chicago, IL 60604
   312-922-2525

4. Nature of order appealed from: Final order of October 30, 2012, which includes adjudicatory order of August 1, 2012

5. Date of judgment being appealed: October 30, 2012

6. This is a timely cross appeal taken pursuant to Supreme Court of Illinois Rule 303(a)(3) related to a notice of appeal filed by the Office of the Public Guardian on November 29, 2012 & received on December 3, 2012

By this cross appeal, K[redacted] S[redacted] asks the Appellate Court to reverse the adjudicatory order of August 1, 2012, entered as a final order on October 30, 2012 of Judge Bernard Sarley, Cook County Circuit Court, Child Protection Division finding physical abuse, neglect injurious environment and abuse substantial risk of injury, or for such other and further relief as the Appellate Court may deem proper.

Ellen R. Domph
Kiran Suryanarayana

Ellen R. Domph
53 West Jackson Boulevard
Suite 1544
Chicago, Illinois 60604
312-922-2525

THIS CROSS APPEAL INVOLVES A QUESTION OF CHILD CUSTODY,
ADOPTION,
TERMINATION OF PARENTAL RIGHTS, OR OTHER MATTERS
AFFECTING THE BEST INTERESTS OF A CHILD
No. 1-12-3472

CROSS APPEAL TO THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

FROM THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
JUVENILE JUSTICE & CHILD PROTECTION DEPARTMENT
CHILD PROTECTION DIVISION

In the Interest of: Marika K[redacted] & Yohan K[redacted],	)	
Minors-Respondents-Appellants,	)	
	)	
(People of the State of Illinois,	)	**No. 11 JA 512, 11 JA 513**
Petitioner,	)	
	)	
v.	)	**Judge Bernard Sarley**
	)	**9I**
K[redacted] S[redacted],	)	
Father-Respondent-Appellee, Cross Appellant,	)	
	)	
Teresa G[redacted],	)	
Mother-Respondent-Appellee, Cross Appellant)	)	

NOTICE OF CROSS APPEAL

Mother-Respondent-Appellee, Cross Appellant, T[redacted] G[redacted], cross appeals to the Appellate Court of Illinois for the First District from the following order entered in the Circuit Court of Cook County, Child Protection Division:

1. Court to which appeal is taken: Appellate Court of Illinois, First Judicial District.

2. Name of appellant , address, and telephone number to which notices shall be sent:

Teresa G[redacted]
C/o Ellen Domph
53 W. Jackson Blvd.
Suite 1544
Chicago, IL 60604
312-922-2525

3. Name, address, and telephone number of trial attorney:
   Ellen Domph
   53 W. Jackson Blvd.
   Suite 1544
   Chicago, IL 60604
   312-922-2525

4. Nature of order appealed from: Final order of October 30, 2012, which includes adjudicatory order of August 1, 2012

5. Date of judgment being appealed: October 30, 2012

6. This is a timely cross appeal taken pursuant to Supreme Court of Illinois Rule 303(a)(3) related to a notice of appeal filed by the Office of the Public Guardian on November 29, 2012 & received on December 3, 2012

By this cross appeal, Teresa G[redacted] asks the Appellate Court to reverse the adjudicatory order of August 1, 2012, entered as a final order on October 30, 2012 of Judge Bernard Sarley, Cook County Circuit Court, Child Protection Division finding physical abuse, neglect injurious environment and abuse substantial risk of injury, or for such other and further relief as the Appellate Court may deem proper.

Ellen R. Domph
Attorney for Teresa Gracias

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53 West Jackson Boulevard
Suite 1544
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312-922-2525

GLOSSARY OF MEDICAL TERMINOLOGY

Arachnoid Membrane
A thin, web-like membrane that lies just below the thick dural membrane. R8.19-20 (Dr. Frim); R5.112 (Dr. Barnes).

Benign External Hydrocephalus ("BEH")
Benign external hydrocephalus a condition impacting the amount of space between the brain and the arachnoid membrane—called the subarachnoid space, which is filled with cerebral spinal fluid. BEH exists when a child has an excessive amount of cerebral spinal fluid, which then causes the subarachnoid space to exceed the normal measurements. R8.8-9 (Dr. Frim); R2.150 (Dr. Wainwright). Other terms used for this condition include "benign extracerebral collections," "benign external collections." R5.51, 94 (Dr. Barnes).

Cerebral Spinal Fluid ("CSF")
A fluid found in the central nervous system that cushions the brain and spinal column, and continually turns over throughout the day. R8.8, 193 (Dr. Frim).

Congenital Rickets
Congenital rickets, also called neonatal rickets, occurs when the mother has a vitamin D deficiency that is then passed on to the fetus, causing the deficiency to be present in a newborn infant from the time of birth. R5.49 (Dr. Barnes); R6.8 (Dr. Sullivan). *See infra* for definition of "rickets."

Craniotabes
Craniotabes is an abnormality often found in infants with congenital rickets and is identified through insufficient bone thickness and irregularities in the suture bones of the skull, which represents incomplete bone formation. R5.102-03, 106 (Dr. Barnes); Barnes Report, E14.8.

Dural Membrane
A thick membrane lining the inside of the skull bone. R8.19 (Dr. Frim)

Extra-Axial
Outside of the brain. R8.48 (Dr. Frim).

Fundus Exam

In a fundus exam, drops are used to dilate the patient's pupils so that an ophthalmoscope can visualize the back of the eye, including the retina. R6.223-24, R7.48 (Dr. Yoon).

Hematoma

Blood clot or bleed. R8.7 (Dr. Frim).

Ischemia

Inadequate blood flow to the brain. R2.126 (Dr. Wainwright).

Lesion

Area of abnormality. R7.182 (Dr. Nicholas)

Macular Fold

An injury to the retina marked by an elevation or fold of the retina instead of being flat against the eye. R7.76 (Dr. Yoon).

Periosteal Reaction

Periosteum is the tissue that wraps around the bone and builds new layers of bone. When there has been a fracture, the bone will bleed underneath the periosteum, which will then lift up and generate new bone from that position. On an x-ray, this periosteal reaction will appear within seven to fourteen days of a fracture as a light onionskin-like layer on either side of the darker mature bone. R6.27-28, 30-31 (Dr. Sullivan).

Posterior

Anatomical reference meaning back; as relating to the head, posterior means bottom or back part of the head. R5.113 (Dr. Barnes); R8.120 (Dr. Burrowes).

Restricted Diffusion

Restricted diffusion is visualized on a brain imaging scan as areas of white brightness, which can be seen in the presence of inadequate oxygen, inadequate blood flow (also called "ischemia"), or seizures. R2.126, 198, R3.14 (Dr. Wainwright); R5.124-26 (Dr. Barnes).

Retinoschesis

Injury to the retina marked by separation of the retinal layers. R7.70 (Dr. Yoon).

Rickets

Also referred to as rachitic bone disease, rickets is a mineralization deficiency in growing bones leading to inadequate bone formation. R3.147 (Dr. Janicki); R5.48-49 (Dr. Barnes); R6.27 (Dr. Sullivan); R4.85 (Dr. Fortin). The most common cause of rickets is vitamin D deficiency, and the most common cause of rickets in an infant of Yohan's age is a vitamin D deficiency passed from the mother in utero (*i.e.*, "congenital rickets"). R4.85 (Dr. Fortin); R5.107 (Dr. Barnes).

Subarachnoid

Below the arachnoid membrane. The subarachnoid space is filled with the cerebral spinal fluid and the arachnoid membrane serves as the boundary for that fluid. In relation to the brain, the subarachnoid hemorrhage is a bleed located in the space between the brain and the arachnoid membrane. R8.8 (Dr. Frim). The subarachnoid space continues to the structures of the eye, including the optic nerve and the retina. R8.27 (Dr. Frim).

Subdural

Below the dural membrane. A subdural hematoma is located below the dural and above the arachnoid membrane. Under normal circumstances, there is nothing separating the dural and arachnoid membranes. R8.7, 19-20 (Dr. Frim); R5.112 (Dr. Barnes).

Venous Thrombosis

Clotting in the vein. Venous thrombosis can occur in either the sinus veins (which are the larger veins) or the cortical veins (which are the smaller veins). R5.93, R5.179 (Dr. Barnes).