2015 IL App (2d) 150218-U
No. 2-15-0218
Order filed August 31, 2015

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

In re B.K., a Minor,	)	Appeal from the Circuit Court
	)	of Kane County
	)	
	)	No. 12-JA-54
	)	
(The People of the State of Illinois, Petitioner-Appellee, v. Kevin K. *et al.*, Respondents-Appellants).	)	Honorable
	)	Linda S. Abrahamson,
	)	Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court.
Justices Jorgensen and Burke concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court's decisions, which were based on voluminous and conflicting medical evidence, finding respondents had violated a term of pre-adjudicatory supervision, were unfit, and that it was in the best interest of the minor that custody and guardianship be placed with the Department of Children and Family Services were not contrary to the manifest weight of the evidence.

¶ 2 I. INTRODUCTION

¶ 3 Respondents, Kevin K. and Jaclyn K., appeal a series of orders of the circuit court of Kane County finding them unfit parents and placing guardianship and custody of the minor, B.K., with the Department of Children and Family Services (DCFS). Respondents raise two main issues on appeal. They contend that the trial court erred in finding that they violated a

condition of supervision imposed in connection with an order of pre-adjudicatory supervision (the order). They also challenge the trial court's determinations regarding their fitness and B.K.'s best interests. For the reasons that follow, we affirm.

¶ 4 Before proceeding further, we note that the State questions our jurisdiction over a portion of this appeal. Specifically, the State contends that we lack jurisdiction over respondents' first issue concerning the trial court's finding that they violated a condition of supervision imposed in the order. The State points out that such an order is not appealable as a matter of right in accordance with Illinois Supreme Court Rule 307 (eff. February 26, 2010). Rather, Illinois Supreme Court Rule 306(a)(5) (eff. July 1, 2014) controls, as it applies to "interlocutory orders affecting the care and custody of unemancipated minors." Rule 306 requires a party to petition for leave to appeal. As respondents filed no such petition, the State reasons, we lack jurisdiction to review the order.

¶ 5 Respondents counter that the State has waived this argument by failing to support it with appropriate authority. However, it is well established that jurisdictional defects cannot be waived (*Mullaney, Wells & Co. v. Savage*, 31 Ill. App. 3d 343, 347 (1975)) and that we have an independent duty to assess our jurisdiction regardless of the arguments raised by the parties (*People v. Fuller*, 187 Ill. 2d 1, 7 (1999)). Thus, respondents' initial response is not well taken.

¶ 6 Respondents also point out that once a final order is entered, "all prior non-final orders and rulings become appealable." More accurately, any order in the procedural progression leading to the final order becomes appealable. *Themas v. Green's Tap, Inc.*, 2014 IL App (2d) 140023, ¶ 7. Thus, respondents had two opportunities to appeal the earlier order. They could have sought interlocutory review pursuant to Rule 306(a)(5), as the State suggests. Conversely, they were entitled to wait until the dispositional order was entered and appealed as a matter of

right. See *In re Leona W.*, 228 Ill. 2d 439, 456 (2008) ("Appealing a dispositional order is the proper vehicle for challenging a finding of abuse or neglect."). Thus, respondents may challenge the trial court's earlier findings in the course of challenging the final order now appealed.

¶ 7 II. BACKGROUND

¶ 8 This case began on May 1, 2012, when the State filed a petition to adjudicate the minor, B.K., neglected. The petition alleged that the minor was neglected in that his sibling, J.K. (collectively, J.K. and B.K. will be referred to as "the minors"), sustained nonaccidental injuries (bruises and fractures) while in the care of respondents or relative caregivers. On July 31, 2012, respondents stipulated "to [the] factual basis as it relates not only [to] the shelter care proceeding, but also the immediate and urgent necessity." They emphasized that "they are not agreeing that they have abused their kids" or that "they are guilty of anything." The State set forth the factual basis for the stipulation:

> "If this were to go to hearing the State would establish probable cause by calling DCFS Investigator John Gac, who would testify that the minor, [J.K.], was being treated at Children's Memorial Hospital where she was discovered to have fractures, bilateral fractures to her femurs, as well as there has been documents of bruises. At this time there has been no medical cause identified and the hospital is indicating that these injuries are consistent with abuse."

The petition was amended to allege that the minor was neglected in that the minor's sibling sustained bone fractures while in the care of relative care givers and respondents failed to protect her. As a factual basis, medical personnel from Chicago Children's Memorial Hospital (which is now known as Lurie Children's Hospital—the parties use both names throughout the record) would testify that J.K. had sustained injuries that were most consistent with those of a

nonaccidental nature. Subsequently, respondents entered an answer denying the allegations of neglect.

¶ 9 A continuance under supervision was allowed prior to adjudication. See 705 ILCS 405/2-20 (West 2012). Numerous conditions were imposed in conjunction with the continuance. These conditions included that respondents would cooperate with reasonable requests of DCFS, that they would notify DCFS within 24 hours of any injury to either child, "which should require medical treatment," and that they would "ensure the appropriate supervision of the minor at all times." On October 29, according to Kevin, he found J.K. choking and nonresponsive. She was transported initially to Sherman Hospital in Elgin and then to Lutheran General Hospital, where she later died. On April 12, 2013, a companion case involving the minor's sibling, J.K., was closed due to J.K.'s death. The State reported that the Cook County Medical Examiner found that J.K.'s death resulted from "blunt head trauma" and was a homicide.

¶ 10 On June 18, 2013, the State filed a motion to revoke pre-adjudicatory supervision and to change custody and guardianship of the minor. The petition alleged that respondents violated various conditions of pre-adjudicatory supervision in that they (1) did not notify DCFS within 24 hours of bruises to J.K.'s legs; (2) "did not provide all necessary care to [J.K.] in that she died of non-accidental injuries while in the care of Mother and/or Father"; (3) "engaged in acts of commission that tend to make the home not a proper place for [B.K.] in that [J.K.] died of unexplained nonaccidental injuries"; (4) "engaged in acts of omission that tend to make the home not a proper place for [B.K.] in that [J.K.] died of unexplained nonaccidental injuries"; and (5) "did not ensure proper supervision in that that [*sic*] J.K. died of unexplained non-accidental injuries." For relief, the motion sought revocation of pre-adjudicatory supervision based on J.K.'s death; a change in custody and guardianship of the minor to the Guardianship Administrator of DCFS;

"findings of Adjudication based on the factual basis presented at the time of the entry of the pre-adjudicatory supervision order"; and the setting of a date for a dispositional hearing.

¶ 11 The State first called Dr. Suzanne Dakil in support of it petition to revoke. Dakil testified that she was a licensed pediatrician and a specialist in child abuse. Dakil had previously been an assistant professor teaching pediatrics focused primarily on child abuse. She further testified that she was currently a "Clinical Professor at the Roosevelt Franklin Chicago Medical School." She also is on the "Cook County Child Death Review Committee" and sits "on the multidisciplinary team for the Northwest Cook County Child Advocacy Center." The trial court recognized Dakil as an expert in the areas of pediatrics and child-abuse pediatrics.

¶ 12 Dakil first became familiar with J.K.'s case in the spring of 2013, and she met J.K. and her family in October 2013 when J.K. was admitted to the ICU at Lutheran General Hospital with cerebral edema (brain swelling). Dakil described J.K.'s condition at the time of her admission as "critically ill." There was no apparent cause of J.K.'s condition. Numerous tests, including a lumbar puncture, CT scan, and MRI, were performed. The lumbar puncture revealed no signs of an infectious disease. The MRI showed that J.K.'s brain was swelling into the area of her brain stem, which causes the loss of brain function. The brain stem is responsible for basic functions such as breathing and heart beat. Dakil found it notewothy that the MRI did not show any blood, which would manifest as "layering or fluid around that brain." Dakil acknowledged that J.K.'s autopsy report indicated that there was bleeding on the brain (subdural hematoma). She explained that in "[i]n cases of severe brain swelling there is a chance that the blood can be pushed against the skull and not visualized on CT or MRI." Blood work was also performed, and it showed no indication of a bleeding disorder or infection. Dakil further testified that nothing in J.K.'s blood work accounted for her condition.

¶ 13 J.K. also exhibited bleeding in the back of her eyes by the retina. According to Dakil, this occurs "almost exclusively" as the result of trauma, such as "shaking and slamming." It could result from "[a]nything that causes abrupt violent movement of the head," for example, a car accident. The medical history taken at the time of J.K.'s admission contained nothing that "would explain retinal hemorrhaging." Dakil explained, "The lack of history is a huge thing in terms of child abuse pediatrics when you start trying to think about injuries."

¶ 14 At the time of her admission, J.K. had "bruising to bilateral thighs, linear parallel marks." Dakil stated that they were consistent with "finger marks" or 'being hit with a linear object." Patterned bruising is concerning because "you don't accidentally bruise yourself in a pattern very often." Dakil noted that Kevin stated that he performed chest compressions and breaths prior to J.K. being admitted, and no bruising was apparent as a result of these procedures. Multiple I.V. sticks did not produce any bruising, nor did holding J.K. down to insert the I.V. lines. Dakil testified that J.K. had no bruises from medical handling. Respondents reported that J.K.'s bruises resulted from her "bouncy seat." Dakil examined a picture of the bouncy seat and explained that "[i]t is designed for infants," and "[t]here is nothing that would cause a pattern bruise like that."

¶ 15 Dakil reiterated that none of the tests performed while J.K. was hospitalized at Lutheran General indicated an organic cause for J.K.'s condition. Therefore, "by virtue of the exclusion of all other possibilities, this was consistent with child abuse." Dakil authored a report expressing her opinions as to the cause of J.K.'s injuries. In making this report, she relied on her colleagues, her own interview with respondents, speaking with J.K.'s other physicians, and J.K.'s medical records. She spoke with an endocrinologist who treated J.K. with vitamin D after she had been diagnosed with rickets. She also spoke with a geneticist, who failed to find evidence of a

metabolic disease or Ehler-Danlos syndrome—possible conditions that had been posited at an earlier time. Further, a hematologist at Lurie Children's Hospital confirmed that they had not found a bleeding disorder to be present. Dakil interviewed respondents and noted they had concerns regarding a lot of medical diagnoses that were not confirmed by other physicians. Dakil opined that J.K "had suffered child physical abuse and inflicted injury."

¶ 16 Dakil stated that she was familiar with the term "constellation of injuries." This term refers to "looking at each -- at all of the pieces of the puzzle, the bruises, the head injury, the eyes, the history, and putting it all together versus looking at one specific thing in a silo [*sic*]." J.K. had a constellation of injuries, consisting of "Cerebral edema and brain swelling, retinal hemorrhages, and bruises." Dakil opined that J.K.'s constellation of injuries, even without a history of trauma, was indicative of child physical abuse and inflicted trauma.

¶ 17 During cross-examination by respondents' counsel, Dakil agreed that she came to her conclusions and diagnosis by exclusion. She further agreed that medical science was constantly developing. She acknowledged that she could identify no subdural hematoma; however, she stated that there was no medical reason to believe it developed after J.K.'s last MRI. Instead, she believed a subdural hematoma was present at the time of J.K.'s admission, but it was masked. She agreed that there were no signs of an external injury to J.K.'s head and that she could find no injuries to J.K.'s neck. Dakil testified that it was possible that a child could sustain an injury of sufficient magnitude to cause "massive brain swelling and subdural retinal bleeding through shaking alone with any associated injuries to her neck [or] the muscles that hold her eyes in place." There was no midline shift in J.K.'s brain during the time she was admitted. Bleeding in J.K.'s eyeballs was beyond the level that would ordinarily result from increased intercranial pressure alone. Dakil acknowledged that J.K. had no "linear grip marks" or any other marks on

her torso, arms, or shoulder resulting from being shaken. Finally, Dakil agreed that lack of oxygen to the brain, which can result from numerous conditions, could result in edema.

¶ 18 On redirect-examination, Dakil testified that there was no definitive test for child abuse. Therefore, absent a confession, such a diagnosis is typically arrived at by excluding other possible causes of a child's injuries. Based on her medical training, she had no reason to believe "that the brain would swell [first] and then bleed." She explained that brain swelling would actually make rupturing a blood vessel less likely, as it would decrease the distance a vessel would have to cover and take pressure off of it. She stated "swelling in and of itself isn't going to cause bleeding." At the time she was admitted, J.K.'s brain was already swelling. Dakil answered affirmatively when asked whether it is "possible to have a shake that is violent enough to cause damage to the brain that doesn't also damage the muscles of the neck, or the muscles around the eye." She later added that it would be possible to cause trauma to the head without having visible injuries to the ribs or arms. She further explained that while it was possible for a retinal hemorrhage to result from intercranial pressure, the distribution of hemorrhaging in J.K.'s eyes was not consistent with such a cause. Instead, the pattern in J.K.'s eyes was diffuse rather than being limited to the area around the optic nerve, which is more consistent with trauma. J.K. had previously been diagnosed with bucket-handle fractures (corner fractures), which "are very difficult to occur in an accidental injury." Dakil acknowledged that her review of J.K.'s earlier injuries did affect her opinion to the extent that "having two episodes of injury" was significant.

¶ 19 The State next called Dr. Marta A. Helenowski. Helenowski testified that she is an assistant medical examiner for Cook County. She performs autopsies. Over respondents' objection, the trial court recognized Helenowski as an expert in the field of forensic pathology. Helenowski performed an autopsy on J.K. on November 3, 2012.

¶ 20 The autopsy began with an external examination of J.K. Helenowski identified a photograph showing pattern bruising on J.K.'s thighs. She stated that the bruises were consistent with fingers or hands. She next performed an internal examination. She removed J.K.'s organs, weighed them, and took tissue samples from various organs, including the liver and kidneys. Slides of the samples were maintained at Helenowski's office, and respondents had access to them. Helenowski found nothing of note in the abdominal cavity, including any sign of an infection or illness. She then examined J.K.'s head. After peeling back J.K.'s scalp, Helenowski noted a subgaleal hemorrhage, which "is basically evidence of bruising under the scalp." Helenowski stated that it was caused by "a direct impact to—in relation, right side of the forehead." No bruise corresponding to this hemorrhage was observed during the external examination. Helenowski explained that this is normal in infants.

¶ 21 Upon opening the skull, Helenowski noted evidence of an underlying hemorrhage and edema. She also observed a "film of fresh red blood on the surface of the brain," which is not normal but an indication of a "subdural hemorrhage or blunt head injury." J.K.'s brain also appeared swollen. Helenowski testified that the swelling would not have caused the bleeding she observed; in fact, it can "cause the arteries to be pushed down and stop bleeding." She further stated that sometimes a subdural hemorrhage that is found during an autopsy will not have appeared on a prior MRI or CT scan. Helenowski found a layer of blood between the dura and the brain, which was unusual. A report from a neuropathologist who examined J.K.'s brain noted no signs of disease.

¶ 22 Helenowski removed J.K.'s eyes, which were sent to Rush University for an ophthalmologic examination. This is a standard procedure in cases of possible child abuse. The examination revealed intraretinal hemorrhages to both eyes, which, according to Helenowski,

meant "that traumatic injury to the head occurred and caused bleeding inside the eye globes." Helenowski's ultimate opinion was that J.K. "died of blunt head trauma due to child abuse."

¶ 23 During cross-examination by respondents' counsel, Helenowski stated that the blood she found in J.K.'s brain would have collected there no earlier than three days prior to the autopsy. She acknowledged various things could cause a brain to swell, such as hypoxia. She stated that J.K.'s pattern bruises were not consistent with her use of the bouncy seat. However, she acknowledged that a child with a "history of easy bruising," might experience "marks" from "repeated contact with an object." Finally, Helenowski noted no external injuries on her abdomen or arms. During questioning by the trial court, Helenowski acknowledged that there was no opposing thumbprint corresponding to the pattern bruising that Helenowski stated could have been caused by fingers or hands.

¶ 24 On redirect-examination, Helenowski testified that there was some clotting in the blood she found on J.K.'s brain. Some blood "wasn't as bright red and as fresh." She also testified that it was possible to have the sort of injury experienced by J.K. without a corresponding external bruise or underlying fracture. She did not believe that the pattern bruising was caused by the bouncy chair, as they appeared to have occurred at approximately the same time. None of the records reviewed by Helenowski indicated a blood or coagulation disorder, and the only thing suggesting that J.K. bruised easily were reports from respondents.

¶ 25 The State's next witness was Brooke Plating of the Youth Service Bureau. Plating was a caseworker in the instant matter. Plating was aware that, on July 31, 2012, respondents had stipulated that J.K. was abused and B.K. was neglected. From this point on, she was working with respondents pursuant to an order of pre-adjudicatory supervision. Respondents would inform Plating when they would take J.K. to the doctor. Plating was concerned that respondents

were taking J.K. to a number of medical specialists in order to obtain a medical explanation for the abuse to which they previously stipulated. Plating explained that if they were not "open to the possibility" abuse had occurred in the past, they might not be able to protect her from it in the future. Respondents were required to fill out "body check forms" to document injuries to J.K.; respondents turned in seven of them. Plating visited respondents' home on several occasions over the next three months and had no concerns about the physical care of J.K. During an October visit, J.K. had a bruise over her right eye. Respondents said that J.K. hit her face on a toy while using the bouncy seat. When Plating visited J.K. in the hospital, Kevin showed her the pattern bruises on J.K.'s thighs and said they had come from the bouncy seat. She did not believe that this explanation "match[ed] the injury."

¶ 26 On cross-examination, Plating identified a report from respondents' counselor, Beth Kowieski. The report contained "only positive remarks" from the counselor. It further stated that respondents had "good insight of their current situation." Plating was aware that respondents had reported to "numerous other people, including doctors" that J.K. bruised easily. She was also aware that Jaclyn was concerned about Rickets, vitamin D deficiency, and Ehlers-Danlos disease. Plating acknowledged that there was no need to notify DCFS of the pattern bruising in accordance with the terms of pre-adjudicatory supervision, as the bruises did not require medical treatment. She further agreed that the doctors respondents sought out to examine J.K. were scheduled before the order was entered on July 1, 2012. She answered affirmatively when asked if it was true that she had never seen anything out of the ordinary at respondents' household. Similarly, interviews with relatives revealed nothing unusual. There were no identifiable risk factors in the household. During cross-examination by the Guardian *ad litem*,

Plating stated that only once did the parents record a bruise resulting from physical therapy in a body-check form.

¶ 27 During redirect-examination, Plating clarified that Kowieski had counseled respondents with respect to coping with J.K.'s death. Her report indicated that respondents "report devastation and anger at the accusations being made" as well as "the medical evidence." They also "expressed disbelief as to how they could be accused of wrongdoing." On recross-examination, Plating testified that J.K. was going to physical therapy once a month. She was initially sent to physical therapy because of a 33% delay in mental and physical growth; however, "the scope of her delay was getting better." Respondents were concerned about the delay. Plating acknowledged that J.K. was treated for and cured of Rickets after the July 31, 2012, stipulation was entered. This treatment, of course, necessitated medical visits.

¶ 28 Respondents' first witness was Officer Scott St. John, of the Elgin police department. St. John stated that he is a detective assigned to the Investigations Division. He spoke with respondents on November 2, 2012. Respondents were cooperative with St. John in the sense that they "always returned [his] phone calls and such." They spoke with him freely and provided him with photographs of bruising experienced by J.K. at different points. He had previously conducted an investigation prior to the July 31, 2012, stipulation while J.K. was still alive, and respondents provided photographs at that time as well. St. John related a conversation that Kevin had with two other officers regarding what prompted him to call for emergency assistance to have J.K. taken to the hospital. Kevin stated that he was caring for the two minors. After he tended to B.K., he returned to J.K. and noted she was in some distress. St. John testified that Kevin stated she was "choking or biting hard." Kevin thought that J.K. was not breathing. As he called 9-1-1, he attempted to give breaths and do chest compressions as instructed by the

emergency-services operator. He stated that there was blood in J.K.'s mouth and she vomited. J.K. died in the hospital.

¶ 29 During cross-examination by the State, St. John testified that he had been involved in an earlier child-abuse investigation concerning J.K. J.K. had bucket-handle fractures, which, in the opinion of the child-abuse pediatrician at Children's Memorial Hospital, were abusive in nature. St. John could not determine who caused those injuries. He stated that the Elgin police are involved in this case because the Medical Examiner's Office ruled that J.K. "died from blunt force trauma, homicide." When asked, "[W]ho are your primary suspects," St. John replied, "The two parents seated here."

¶ 30 Diane Englund next testified for respondents. Englund is Jaclyn's mother. At the time of the hearing, she had known Kevin for over eight years. In the spring of 2012, she noted bruises on J.K... Further, J.K. could not lift her arm. Englund believed that something was wrong with her from the time of her birth. A neonatal nurse told them not to speak loudly around J.K. or touch her because it would cause her to cry. When she would visit respondents, Englund noted bruises on J.K. J.K. was not a "good eater." She would throw up after eating. Englund babysat J.K. on October 27, 2012. J.K. was "crabby," vomited after being fed, had a respiratory infection, did not want to sleep, and simply wanted to be held. On that day, she noted the pattern bruises on J.K.'s legs, and Kevin told her they were from the bouncy chair. At the time Kevin told her this, J.K. was sitting in the bouncy chair. She had, in fact, observed J.K. in the bouncy chair on several occasions. She stated that J.K. "loved it."

¶ 31 During cross-examination, Englund stated that she had no medical background beyond having gone to school for phlebotomy. She loved her daughter, thought highly of her, and believed she is good, kind, loving, and caring. She believed Jaclyn was a good mother. She felt

similarly about Kevin. She observed respondents with J.K. and never had any concerns. J.K. was "fussy and cried a lot" "[l]ike any normal baby would, but a little bit more because of the fact that she seemed like she was in pain." When asked whether B.K. was a fussy baby, Englund replied, "Not like [J.K.]" Englund stated that B.K. belongs with respondents and that it is her understanding that if J.K.'s "death was not from child abuse that that means [B.K.] goes home to his parents." On redirect, she stated her love for her daughter would not cause her to lie under oath.

¶ 32 Respondents next called Dr. James Bryant. Bryant testified that he is a pathologist. The trial court recognized him as an expert in that field. On November 9, 2012, he went to a funeral home to conduct an external examination of J.K. There had already been a prior autopsy. He noted that his was not a complete examination, rather, it was a "second look autopsy." This put him at a "disadvantage," as "some things [were] missing." The adrenal glands, brain, and kidneys were not present, and other organs were present in a bag. He noted "some early pneumonia, which would be consistent with what I now know to be a period of stay in the hospital." He also observed congestive heart failure, which, he testified, was the "last thing that happened to the baby." He harvested some tissue for genetic testing. He examined slides that Helenowski showed him, and he noted nothing remarkable. Brain slides showed a subdural hematoma. There was also subarachnoid bleeding. When Bryant examined the brain, it was in fragments. He could identify general parts, such as the cerebellum, but he could not identify the various parts of the cerebellum. He noted an area of hemorrhage in "white matter, which is deep in the brain." This is significant as there would have had to be some "very forceful trauma" to get a hemorrhage that deep. The only other thing Bryant could identify that would cause such bleeding is a bleeding disorder "that does not have exterior force involved but is involved

interior." There was no exterior sign on J.K. of any trauma of the magnitude necessary to cause such a deep hemorrhage.

¶ 33 Bryant described a condition called "respirator brain," where a person on a respirator does not get enough oxygen to the brain. The brain becomes "mushy." He continued, "[T]he mushiness might expand a little bit." He opined that the ultimate cause of J.K.'s death was congestive heart failure and pneumonia. Heart failure was the result of "some problem inside the brain in the head." However, he stated that he could not say what caused the bleeding in and swelling of her brain. He did not believe trauma caused J.K.'s head injuries, as there was no exterior injury, and he further opined that the subgaleal hemorrhage resulted from an internal source for the same reason. Moreover, there was no corresponding damage to the skull beneath the subgaleal hemorrhage. Bryant examined X rays taken by the medical examiner and noted that, contrary to the initial report of fractures to J.K.'s femur, he could find no evidence of fractures. He testified that even though six months had passed, he would still expect to see signs of healing. Bryant examined a photograph of the pattern bruises and described them as "three thin lines that seem parallel to each other." He stated that the bruises were too thin to have resulted from fingers. After examining a picture of the bouncy seat, he stated that it could have caused the pattern bruises. Furthermore, the extensive medical treatment J.K. received could have resulted in bruising. He also pointed out that though J.K. had not been diagnosed with Ehlers-Danlos syndrome, Jaclyn had been, and it is a genetic disorder. Ehlers-Danlos "is a connective tissue disorder which can give rise to spontaneous bleeding due to a lack of integrity of the vascular system." Bryant testified that he could rule out trauma as a cause of death to a reasonable degree of medical certainty due to the absence of bruising on J.K.'s head.

¶ 34 During cross-examination, Bryant acknowledged that he is neither a neurologist, geneticist (though as a biology major, he had some experience with the subject), nor a specialist in the skeleton. He is also not a *forensic* pathologist. He further acknowledged that he was being paid for his testimony. He does autopsies on a daily basis. He was aware of professional standards for performing an initial autopsy; however, he was unsure as to whether there were standards concerning a second-look autopsy. He agreed that standard protocol is to review whatever background information is available. He, in fact, reviewed some medical records in this case, specifically records from Children's Memorial Hospital and Sherman Hospital. This review was not documented in his report. Bryant stated, "I never do that." He agreed that, though he believed that J.K.'s bruises were unrelated to her death, it was possible that they resulted from abuse. Based on his examination, outside of the specific causes of her death, J.K. appeared to be a "normal child." Bryant explained that though there was no indication that J.K. had a seizure of any sort, he stated it in his report as possible that she had a seizure at the time of her death because he could not rule it out. He explained, "To me, it's kept open because I have no idea by looking at the autopsy whether there was a seizure or not." He agreed that damage to the brain stem could also cause congestive heart failure. Moreover, swelling of the brain can put pressure on the brain stem and cause it to malfunction to the point that death results. In this case, the damage to J.K.'s brain he observed could have led to the failure of her heart. Bryant did not know if he had been given or had read the medical records from Lutheran General Hospital.

¶ 35 Dr. Steven Abern next testified for respondents. Abern is a pediatric neurologist and has been licensed in Illinois since 1978. He is board certified in neurology, pediatrics, and psychiatry. The trial court recognized him as an expert in the field of pediatric neurology.

¶ 36 Abern reviewed J.K.'s medical records and authored a report containing his opinions regarding J.K.'s death. He testified that the cause of J.K.'s death was "malignant intracranial hypertension or she had increased intracranial pressure." He opined that there was no abusive head trauma. He explained that it was extremely unlikely that two CT scans and an MRI would have missed the subdural hematoma. He noted that about 3-1/3 ounces of blood was discovered during the autopsy (Dakil testified that this amount was actually blood mixed with other fluid). Abern opined that the subdural hematoma developed after the last scan. He further observed that there was no localized injury on the brain itself, which would typically result from trauma. Moreover, when a baby is shaken, one would expect to find some injury to the neck. Retinal hemorrhages can result from increased intracranial pressure.

¶ 37 Abern described J.K. as "metabolically *** a mess." She was hypokalemic, hyponatremic, acidotic, and "had abnormal coagulation studies." Her D-dimers were abnormal (a D-dimer "is a measure of the breakdown parts of the coagulation between the thrombin and plasma"). Abern explained that "D-dimers are a test for DIC" (disseminated intravascular coagulopathy[1]) and is "usually found in abnormal bleeding tendencies."

¶ 38 Abern reviewed the report of Dr. Reyes. Reyes diagnosed "herniation *** with subdural hemorrhage" and also reported that "the microscopic [*sic*] shows injuries to mainly the cerebellum." Reyes described an hemorrhage into the folds of the cerebellum. Abern also opined that the subgaleal hemorrhage was unrelated to the "subsequent finding in the head" because nothing was found on the underlying bone or the frontal areas of the brain during medical scans and that rickets could make it easier for J.K. to "show some bruising or bleeding."

[1] "Coagulopathy" is defined as "a disease affecting the coagulability of the blood." Stedman's Medical Dictionary 371 (27th ed. 2000).

Based on his review of J.K.'s medical records, Abern stated that there were indications of coagulopathy problems prior to her final admission to the hospital. He noted that she was evaluated for "easy bruising" at two-months of age. One doctor wanted to give J.K. a platelet transfusion.

¶ 39 During cross-examination by the State, Abern stated that he had no subspecialty related to child abuse. He was being paid $500 per hour to testify and $300 per hour for reviewing medical records. Abern was asked whether, in his report, he ever indicated that J.K. had actually been diagnosed with a particular condition. He replied that nowhere in his report did he "say she had this, she had that." He continued, "That's not my intention in that report." Rather, he simply listed a numbr of diagnoses that had been considered. He thought "[t]here was some question of" a coagulopathy problem at Children's Memorial Hospital. However, he believed that "[t]hey thought that she probably did not have one," but "[t]hey did not rule it out." He agreed that J.K. had symptoms of a subdural hematoma, but stated that her symptoms were consistent with numerous other things as well. His opinion that the edema came before the bleeding was based on the MRI, CT scans, and J.K.'s clinical presentation. Abern testified that J.K.'s condition was not the result of abusive head trauma to a reasonable degree of medical certainty, but he also stated that he could not "rule it out entirely."

¶ 40 The State then recalled Dakil in rebuttal (out of order). She explained that a bruise results from blood being pushed from crushed capillaries to the side of where pressure had been applied. Thus, if someone grabbed a person's limb and squeezed hard enough to cause a bruise, linear bruises would appear in the space between the fingers. The bruising on J.K.'s legs was not related to her death. However, the bruises were "concerning for abuse." Outside of low vitamin D, Dakil noticed nothing unusual about J.K.'s blood work prior to her final hospitalization at

Lutheran General Hospital. At Lutheran General Hospital, her blood work indicated that her sodium and potassium levels were low, her blood was acidic, and her D-dimers were elevated ("meaning her blood was not clotting and moving properly"). However, Dakil testified, this was not abnormal in the context of her condition, as she was "critically ill and in the process of dying." Nothing indicated the existence of a virus, genetic disorder, or blood-coagulation disorder. Dakil disagreed with Abern's opinion that J.K. had a bleeding disorder. While J.K. carried MRSA, she was not acutely infected, meaning she did not require treatment for it. She further disagreed that the fact that J.K. was taking Flagyl (which J.K. was taking for a colon infection) would mask meningitis or sepsis. Moreover, while it is true that J.K. had a colon infection (C. Diff or Clostridium difficile), it is not associated with cerebral edema.

¶ 41 Dakil agreed that shaking was a form of abusive head trauma. Bleeding typically begins immediately, but "[w]hether we know about it or not is questionable." When asked whether the brain impacts the inside of the skull, Dakil replied, "It can, but it doesn't have to." It can result in a specific area of trauma, but it does not have to. Dakil explained that most shaking injuries are not localized. Further, when you have a diffuse injury, equal pressure occurs throughout the brain, and there is no midline shift. Because the dura surrounds the brain, blood can "layer out over both hemispheres. This is the sort of bleeding observed in J.K. Dakil testified that death can result from shaking alone and that it is possible to shake a child to death without leaving external injuries. As for a neck injury, Dakil stated, "We don't know why, but it seems that there are plenty of cases of not being able to identify neck injury in cases that have abusive head trauma." There was no injury detected to J.K.'s neck, though no MRI was performed on that portion of her body.

¶ 42 Dakil stated she usually does not ask for an MRI "until at least three days after the injury." J.K.'s MRI was performed within 24 hours of her admission to the hospital. She also disagreed with Abern's opinion that J.K.'s condition was most likely the result of an internal condition such as a bleeding disorder. She noted that there was no indication that J.K. had a bleeding disorder prior to her admission. She agreed with Abern that J.K. was a "metabolic mess," but explained that this was a result of whatever trauma she experienced. Finally, Dakil testified that retinal hemorrhaging caused by intracranial pressure is limited to small hemorrhages around the optic nerve whereas retinal hemorrhages from shaking are "numerous and extend to the periphery." J.K.'s retinal hemorrhaging was of the latter sort.

¶ 43 During cross-examination, Dakil acknowledged that most of J.K.'s blood work was abnormal by the time she was admitted to Lutheran General Hospital. She agreed J.K. was experiencing DIC. Prior to taking Flagyl (and also prior to her admission), J.K. took two other antibiotics. She further agreed that an edema could result from suffocation and that J.K. was "reportedly choking and gagging prior to her presentation at Sherman." However, though J.K. had some respiratory issues, none were of sufficient magnitude to warrant hospitalization.

¶ 44 Heather K. next testified for respondents. She is Kevin's sister. She stated that she would not lie for her family. She served as a temporary foster parent to J.K. and B.K. for about three months. They resided in respondents' residence at the time. She never saw respondents strike either of the minors or use any form of corporal punishment. Respondents handled the minors with care and were loving and caring parents. Heather was aware of J.K.'s medical issues and took her to medical appointments. She took J.K. to unscheduled medical appointments about every week to two weeks for illnesses. J.K. was lethargic, constipated, extremely fussy, and was not eating or sleeping regularly. B.K. had no similar issues. Heather

noted bruises and rashes on J.K. on an almost daily basis. She never observed respondents cause any of the bruises or red marks, and they occurred when respondents were not around. J.K. would cry sometimes despite not having any apparent needs. J.K. would "throw up abnormally." Heather was required to record J.K.s bruises on sheets provided by DCFS (at times throughout the record, the parties and trial court refer to these as "bruise sheets"). The bruises were becoming more frequent from May to July 30, 2012. Despite the numerous bruises, no one from DCFS sought to remove J.K. from Heather's care or directed her to seek medical care for J.K. Based on her experience as a babysitter, J.K. did not act like any other baby Heather had previously encountered.

¶ 45 During cross-examination, Heather acknowledged that she loved and respected her brother and admired her sister-in-law, believing her to be a loving mother and a kind person. She stated that she would do what she could to help them get B.K. back and did not believe respondents would do anything to harm him. Several sheets document a recurring bruise on J.K.'s chin. Another recurring bruise appeared over J.K.'s right eyebrow. Heather could not recall the extent to which she filled out the sheets as opposed to Jaclyn filling them out. At one point, a physical therapist told Heather that J.K. was getting healthier and stronger.

¶ 46 The State next called Brooke Plating in rebuttal. After J.K. was returned to respondents' care (following the time during which Heather was providing foster care), Plating first noticed a bruise on J.K. on October 8, 2012. J.K. had a bruise near her right eye, which purportedly occurred when she "knocked her head on one of the toys on the bouncy seat." Outside of that bruise, Plating observed no other bruises until the time J.K. was admitted to the hospital. Kevin also gave Plating a sheet documenting a bruise by her left eye from the bouncy sheet. Kevin also showed Plating pictures of J.K.'s MRSA. It appeared to be getting better over time. Plating

reviewed reports from J.K.'s physical therapist. They stated J.K. was getting stronger, and there was no indication that J.K. suffered any bruises during therapy. A pediatrician "was not too concerned" about J.K.'s vomiting, as she was putting on weight. Plating testified that the sheets recording J.K.'s injuries did not accurately depict her condition. According to Plating, while the sheets referenced "multiple marks on her body on a daily basis," when Plating saw J.K. "she did not appear to have bruises or markings all over her body." Plating continued, "She appeared to be healthy and I don't believe that the sheets fully reflect that." When she saw the marks documented as broken blood vessels, "They were just tiny red dots on her skin when [she] saw them." Following the resolution of various motions, proofs were closed at this point and the case proceeded to closing arguments.

¶ 47 On October 31, 2013, the parties reconvened for the trial court's ruling. The court first noted that respondents entered into an order pertaining to the minors stating that, *inter alia*, they would "refrain from acts of comission or omission that tend to make the home not a proper place for them;" they would provide all care, including medical care, necessary for their protection; and that they would "ensure the appropriate supervision of the minors at all times." The court noted that if the State showed that this order was violated, a finding of neglect would enter as to B.K. The neglect finding "would be based on [respondents'] stipulation on July 31st that their failure to protect [J.K.] from nonaccidental fractures created an environment injurious to [B.K.'s] welfare." The case would then be set for disposition. The trial court stated that the first basis identified above would require proof "that a parent did or did not do something." It further stated that it disagreed with respondents that the second two required her to find that someone "bound by the [order] hurt [J.K.]" These two allegations "could be summarized as requiring protection of these children from harm," so, the trial court continued, if the State proved that J.K.

died as a result of nonaccidental or blunt force trauma, it would have shown that respondents failed to protect her.

¶ 48 The trial court first found, based on respondents' stipulation of July 31, 2012, that J.K. had metaphyseal fractures. As such, that question was foreclosed in the instant proceeding, and the fact that they did not show on subsequent X rays was not relevant. The trial court noted that there were problems with both sides' theory of the case: for the State, the lack of a visible subdural hemorrhage upon J.K.'s admission as well as the absence of external trauma; for respondents, that there was no organic explanation for J.K.'s many symptoms and eventual death.

¶ 49 The trial court further found that J.K. had been "colonized" with MRSA, but was not acutely affected at the time of her death. J.K. was taking antibiotics immediately before her death. At the time she was admitted to Sherman Hospital, J.K. was suffering from "significant global swelling of the brain." She also had pattern bruising to both legs. Respondents were cooperative with law enforcement. The trial court noted various medical symptoms that were not connected to J.K.'s death by medical testimony and the trial court did not, therefore consider in relation to the instant ruling.

¶ 50 The trial court found that most of J.K.'s purported bruising was based on reports by respondents. It rejected Bryant's opinion that the subgaleal hemorrhage was caused by an internal source, as it was contradicted by three other doctors. It also found that the sheets on which J.K.'s injuries were recorded to be entitled to little weight. Though the trial court found Heather credible, it also stated she was biased in respondents' favor. It noted respondents' role in filling out the sheets and questioned how Heather would know what a broken blood vessel looked like. The trial court observed that the number of marks documented diminished after

custody was returned to respondents and posited that this was either because Heather was recording marks that were not significant in nature or that whatever was causing them had resolved by that time.

¶ 51 As for the pattern bruises, the court noted that they were parallel and equidistant from each other. Thus, the trial court found, it was unlikely that they occurred repetitively from three or four separate impacts that just happened to make such a pattern. Regarding the retinal hemorrhaging, the trial court noted that neither their presence, size, nor shape were disputed. It noted that Bryant and Abern offered no opinion about them, but Dakil and the expert who examined them at Helenowski's request both believed they resulted from trauma rather than intracranial pressure.

¶ 52 The trial court found Abern credible and unbiased, but it noted that while he testified "what he believed [J.K.'s] injuries were not, he did not state what they were or even what they could be." It observed that his opinions relied heavily on his belief that it was extremely unlikely for the MRI and CT scans to have missed the subdural hematoma, given its size. Bryant, stated the trial court, opined that the deep bleeding found in the white matter of J.K.'s brain could only come from forceful trauma or a bleeding disorder, and he identified no bleeding disorder. While Bryant was credible and unbiased, the trial court attributed less weight to his testimony because he had conducted a "second look autopsy" which gave him less access to data and he did not testify that he had any expertise regarding abusive head trauma in child-abuse cases. Helenowski, who the trial court also found credible and unbiased, explained that head trauma can come from the brain hitting the inside of the skull. It acknowledged Helenowski's relative inexperience as well as her specialized training.

¶ 53 The trial court stated that in resolving the conflict in the opinions of Dakil and Abern, the primary issue was the significance of the fact that the subdural hematoma did not appear on the CT scan or MRI. Abern interpreted this as meaning the hematoma was not present; Dakil, "having had experience with patients whose subdurals did not appear on a scan and having an explanation as to why they might not," did not rule out abusive head trauma on this basis. The trial court further noted Dakil's reliance on the nature of the retinal hemorrhaging in formulating her opinion. It then went on to hold:

> "I find Doctor Dakil credible and unbiased. Although her years of experience are fewer than Doctor Abern, I give her greater weight than Doctor Abern in that her expertise in child abuse allowed her to pull together all of [J.K.'s] symptoms in a logical way. I disagree with the parents' argument that that made—that her expertise makes her predisposed to only find child abuse, in that her reasoning for each opinion appeared to be logical and objectively based on the facts in [J.K.'s] case."

The trial court then found that the State had proven by a preponderance of the evidence "that someone hurt [J.K. and] that she suffered abusive head trauma which led to her death." It continued that since the perpetrator is unknown and since it was respondents' responsibility to keep her free from harm, respondents had failed to provide the necessary care she needed and failed to properly supervise her. It then found that B.K. was a neglected minor and set the matter for disposition.

¶ 54 A dispositional hearing was set for November 26, 2013. Respondents also filed a motion to reopen proofs, which was set for that day. Respondents first sought to present the testimony of Dr. Michael Laposata, an expert on blood and genetics. The trial court granted the motion.

¶ 55 On March 10, 2014, an evidentiary hearing was held at which Laposata testified. Laposata is a professor of pathology at the Vanderbilt School of Medicine. He treats patients that have bleeding and clotting disorders. He also teaches medical students and doctors. He has consulted in cases of child abuse in the past, and he stated that most such cases actually do involve child abuse. However, he said, "as with any diagnosis, there is a rate of error, and the rate of error for child abuse case [*sic*] is too high and it's preventable." The trial court recognized Laposata as an expert in the fields of bleeding, clotting, and clinical pathology.

¶ 56 Laposata was contacted by Jaclyn and asked to investigate this case to see if there was another explanation for J.K.'s "underlying disease." He asked a colleague to attempt to sequence J.K.'s DNA, but the sample had degraded to the point where it was not possible to do so. He noted that there was evidence that J.K. had a bleeding disorder from birth. He cited her reported easy bruising, and he noted that other doctors "had actually identified a coagulation disorder," but then "just discarded it for reasons that [were] not clear to [him]." Laposata decided to follow up "because it had an answer." He testified that he was not being compensated for his testimony.

¶ 57 Laposata opined that J.K. had a bleeding disorder from birth. He stated that a medical report noted neonatal ecchymoses (bruising at birth). There were indications of bruises where J.K. had been in contact with objects. Lab tests documented a bleeding disorder, specifically, an abnormal result on a platelet aggregation study. He explained that in a person without symptoms of bleeding, this would not have been significant; however, "in a patient who does have bleeding symptoms, it's extremely important." Additionally, J.K.'s elevated D-dimers indicated that she was "trying to make clots," as "that's a breakdown product of a clot." Moreover, two screening tests for platelet function were performed. One was normal; one was abnormal. A low vitamin D level affects platelet function. Laposata noted that after J.K.'s vitamin D deficiency was

treated, "her picture, her bleeding, bruising improved for a short period of time." However, vitamin D supplementation did not help "enough to give her normal platelet function and prevent her demise."

¶ 58 Laposata reviewed the results of a platelet aggregation test which showed a "marked abnormality." The platelets' response to an agent that stimulated clotting was only 22% of normal. If he was treating a patient with such a test result, he "would immediately work on a treatment to determine how to stop [the] bleeding, because [he] would know it's coming back again." Laposata continued, "As far as I can tell all the abnormalities were ignored." He stated that J.K.'s history of bruising was "very important" to his diagnosis. Nevertheless, such a test result would be concerning even absent the history of bruising.

¶ 59 He characterized J.K.'s "baseline" disorder as "mild to moderate." He explained, "if you already have platelets that don't work, it's important to not give anything to this child that will make them work even more poorly, because then you push them over the edge." Such a patient would have to avoid hundreds of medicines. Laposata noted that in the autopsy, marks and bruises were found all over J.K.'s body. This led him to be concerned that another coagulopathy was involved. An infection can produce a clotting disorder called DIC (disseminated intravascular coagulation). In the final days of her life, two additional test results were abnormal, specifically, the D-dimer test and the prothrombin time test (PTT). Both were signs of DIC. Laposata testified that Amoxicillin, which J.K. had been given shortly before her death is one of the medicines that she should not have been given, as it "inhibits platelet function." Amoxicillin's platelet-inhibiting effect would persist for two to three weeks after a person stops taking it. Laposata also pointed to the fact that J.K. was given heparin flushes with other medications. He explained that heparin will increase PTT and it may slow clotting. Amoxicillin

in itself could be fatal to a child with a lab profile like that of J.K. Laposata opined that J.K. died as a result of a blood disorder exacerbated by medicines and DIC. He was certain (to a reasonable degree of medical certainty) that no trauma had occurred, as he was certain she died from a coagulopathy.

¶ 60 During cross-examination, Laposata agreed that J.K.'s personal history, as reported by her family, was important to his diagnosis. He further agreed that inaccurate information about a patient's history can lead to a misdiagnosis. Certain marks on J.K. (petechia[2]) occur in children without blood disorders. He acknowledged that he cannot tell how an injury occurred simply by looking at a picture. Rather, he relied on what J.K.'s parents told him about the cause of an injury.

¶ 61 Laposata testified that in a child that bruised from things like lying on a pacifier or wearing a headband, it would be probable that a blood pressure cuff or being restrained during an eye examination would also cause bruising. He would also expect to see a bruise from a puncture from a blood draw. He agreed that bruising would continue regardless of location (*i.e.*, at home versus at the child's grandmother's house).

¶ 62 Other conditions could cause a child to bruise easily, including a vitamin D deficiency. J.K. was diagnosed and treated for such a deficiency. Following treatment, her bruising improved. Outside of the neonatal ecchymosis, the hospital documented no other bruising following J.K.'s birth. A person with a mild platelet disorder takes longer to stop a bleed, but bleeding typically does stop. Laposata testified that some of J.K.'s test results for red blood cell levels were slightly below the normal range, but not enough to be concerning. However, he

[2] "Minute hemorrhagic spots, of pinpoint to pinhead size, in the skin, which are not blanched by pressure" (Stedman's Medical Dictionary 1356 (27th ed. 2000))

continued, "it could be a clue that she [was] bleeding a little extra." During her final hospitalization, J.K. was dying. Laposata would expect abnormal blood results from a dying person. He agreed that test results can vary from person to person and test to test. J.K.'s result for the platelet aggregation test could "be seen in normal people" who do not have a bleeding disorder.

¶ 63 Laposata agreed with the hematologist who treated J.K. that the most likely diagnosis was some sort of mild platelet defect, of which there are hundreds of types. The hematologist's report also states that further testing should occur if J.K.'s problems continue. Respondents did not seek further testing. Moreover, the only abnormal result was the response of J.K.'s platelet's to epinephrine, though other types of tests were performed. Laposata acknowledged that "an abnormal response to epinephrine is generally considered mild." A child can have a blood disorder and still be the victim of child abuse. Laposata has published two articles on child abuse, both of which relate to its over-diagnosis.

¶ 64 Laposata testified that, as J.K. was so affected by her blood disorder as to have a spontaneous bleed in her brain, her ability "to plug holes [got] worse." When asked whether he would expect such a patient to show bruising and bleeding elsewhere, he replied, "Often." It would "probably" not be limited to one area of the body. Bruises could result from medical procedures, such as blood pressure tests and I.V. lines. He noted that the veins in the head are more easily ruptured. Laposata had reviewed the report of the medical examiner. It documented several bruises: one on her chin that may have been from a neck collar; one in her armpit area; bruising on each leg; and one on her foot. No bruising was noted at her I.V. sites.

¶ 65 On redirect-examination, Laposata explained the elevated D-dimers indicate that J.K.'s body was attempting to form clots, but they were breaking down. Treating J.K.'s vitamin D

deficiency could have resolved part of her platelet disorder, but not all of it. Having reviewed J.K.'s medical records, Laposata testified that no one recognized that J.K. had a platelet disorder or treated her for one. At the time of her death, J.K.'s platelet disorder was "severe" due to "all the additive factors that impair platelet function" (medications, infection, vitamin D deficiency, and DIC). On recross-examination, Laposata agreed that after the body forms a clot, it then breaks down the clot, "Otherwise, we would all be covered with scabs." This is a normal process. At J.K.'s one-month examination, Jaclyn stated that "she was not aware of any family history of bleeding."

¶ 66 A further hearing was held on June 9, 2014. The State again called Brooke Plating. She testified that she had been the caseworker on B.K.'s case since its beginning. A client service plan identifies services for respondents, which included undergoing a psychological evaluation and counseling services. Plating secured approval for respondents to begin these services in February 2014, and she met with respondents to discuss these services at this time. She subsequently spoke with them about it twice. They declined to start these services in May 2014 (the first date available) due to a scheduling conflict, though they stated they could begin in mid June. Both respondents were participating in individual therapy with Beth Kowieski at the time of this hearing. Plating stated, "They should be addressing their current legal situation as it involves their DCFS involvement, as well as processing the medical explanation that was given in the autopsy for [J.K.'s] death." However, on reviewing Kowieski's notes, it appeared that "they have not necessarily acknowledged the possibility that J.K. was abused." She later explained that this was one of the most important parts of the service plan, as it "deals directly with the issue [for which] this case came into care." Instead, they focus on "their legal battle." As such, they are rated unsatisfactory on this service. They are rated unsatisfactory "because

they have not acknowledged that it's possible that [J.K.] was abused and if that acknowledgment can't be made, it would be hard to recommend return home in the future." Plating also questioned Kowieski's objectivity, explaining that her reports speak "a great deal to their character and what other people in the community think of them, rather than her professional therapeutic assessment of them." Plating also testified that it was her understanding that Kowieski "donated to a fund raising website that [respondents] have going." Respondents "have a Go Find Me[3] [*sic*] website to assist them in the cost for their legal expenses." Kowieski's husband is listed on the website as a donor of $1,000. Also, Kowieski "initially stated that she was [providing services to respondents] *pro bono*." However, respondents informed Plating that Kowieski was billing their insurance company. DCFS has asked that respondents undergo counseling individually, rather than together as they do with Kowieski.

¶ 67 Respondents each visit B.K. once a week for two hours. They also spend "face time daily and are also allowed phone contact." Currently, DCFS, which has discretion concerning visitation, is operating under its understanding that the trial court's earlier decision that respondents were responsible for J.K.'s death remained in effect. It is aware that proofs have been reopened. Respondents have asked that it consider Laposata's testimony in making decisions. However, the decision maker (Plating's supervisor) had not heard Laposata testify, as respondents had moved to exclude her from the hearing. Given the current legal posture, safety is a major concern. B.K.'s foster family (grandparents) does not believe that J.K. was abused. Plating stated that this was not a concern in terms of them being caregivers, but it was a concern

[3] Plating was apparently referring to a GoFundMe website, a site dedicated to raising money for "personal causes" and "life events." See http://www.gofundme.com/stories/welcome (last visited August 13, 2015).

regarding their supervising visits with respondents. Plating further testified that the foster family has complied with all rules imposed by DCFS.

¶ 68 On cross-examination by respondents, Plating stated that the parents are rated unsatisfactory on their service plan as they have not done their psychological evaluations. Plating acknowledged that "the parents are satisfactory in all domains except for one, the domain of processing medical explanations of [J.K.'s] death and their cooperation in the psychological evaluation." Regarding respondents attending counseling individually, Plating stated that it had been discussed with them, "but it is not, I would say, the major concern in this case," so it has not been revisited. The prior foster parents (paternal grandparents) reported that B.K. was having difficulties following visits with respondents. His prior foster parents stopped taking care of B.K. because of their own personal-health issues.

¶ 69 On redirect-examination, Plating testified that it was not unusual for a child to cry at the end of a visit. DCFS does not consider this particularly alarming. On recross-examination, Plating acknowledged that respondents had been rated satisfactory on processing their current legal situation with their counselor, despite having engaged in counseling jointly.

¶ 70 When the proceeding recommenced on August 1, 2014, the State called Dr. Shannon Carpenter. Carpenter testified that she is a pediatric hematologist and pediatric oncologist and is board certified in these fields. She treats children with bleeding and clotting disorders. Carpenter estimated that she had treated "thousands" of patients, about 90% of which were children. Approximately a quarter of the children were under a year of age, as congenital bleeding disorders tend to present in the neonatal, the baby[,] age group." She encounters two to three cases per month where child abuse is a concern. Carpenter is also an associate professor. Treating children for coagulation disorders is different than treating adults, as the coagulation

system develops over time. Carpenter added, one has "to understand the developmental differences in children at different ages compared to adults." She continued, "There is variability particularly in babies in terms of how platelets respond compared to adults."

¶ 71 Carpenter is on a committee on "DNA testing or genomic diagnosis of bleeding disorders." The goal is to identify children with coagulation disorders at an earlier point. She explained that they have encountered various problems:

> "One of the things that happens in the sequence of genome is you find these variance of uncertain significance and you can't assign a disease to those based upon just having a variant there. You have to be able to know that it is actually causing some problem.
>
> In addition, there are various ways a gene can be abnormal and some of the ways that a gene is abnormal can't be picked up by genome sequencing. For very technical reasons, the genome sequencing doesn't know which way it is reading. So if the gene gets turned around and is being read the wrong way, it won't be—it won't be read appropriately when it needs to make the protein. But the genome sequencing doesn't see it, it just sees that it is there. It doesn't know which way it is being read and directionality is important."

The trial court recognized Carpenter as an expert in pediatrics, hematology, coagulopathy, pediatric hematology, and pediatric oncology.

¶ 72 Carpenter was asked to review this case to determine whether J.K.'s death was the result of a blood disorder. When she evaluates a case, she develops a list of potential diagnoses that "fit the criteria of what might be going on with a given patient." She then orders tests to rule in or rule out various diagnoses to develop a "differential diagnosis." This is taught from the

beginning in medical school. She did not believe Laposata proceeded in this manner in this case. Carpenter explained that "evidence based medicine is the practice of providing care and making diagnoses on the best available and most up-to-date evidence and evidence being data which is accumulated through studies." She believed Laposata was basing his diagnosis on "possibilities as opposed to data" and that he was "guessing to a certain extent." A hypothesis, Carpenter continued, is "where you start, not where you end."

¶ 73 Bleeding disorders, including platelet function disorders, may be categorized mild, moderate, or severe. A platelet function disorder related to epinephrine is usually mild. Mild bleeding disorders are "very benign." Typically, Carpenter would bring such a patient into the clinic "to remind them that they have a mild bleeding disorder often." The patient would have nosebleed, gum bleeds, bruising, and bleeding with surgery or trauma. Carpenter would expect the patient to "have a normal life span and to live a very healthy and good life." She added that many with such disorders are never diagnosed as they are "pretty mild." In a patient with a blood disorder that was severe enough to cause bleeding into the brain, Carpenter would expect to see symptoms in other parts of the body as well.

¶ 74 Having reviewed J.K.'s medical records, Carpenter opined that the tests ordered by her doctors were appropriate. She noted that lab testing, which she characterized as "fairly extensive," did not identify a blood disorder. She further opined to a reasonable degree of medical certainty that J.K. did not have a blood disorder.

¶ 75 Reference ranges for laboratory tests are sometimes different for children and adults (a reference range is the range that a test would fall within to be considered normal). It is possible to be outside a normal range and not have a bleeding disorder. Platelet counts will increase in response to stress. In five of eight tests, J.K.'s platelet count was high, which could have been in

response to stress. Regarding platelet function analysis testing, Carpenter testified that the PFA-100 (PFA) is a screening test. It simply alerts doctors to the possibility of a diagnosis rather than actually diagnosing a disorder. The PFA is less reliable for infants because their "platelets don't respond quite the same way." Reference ranges are not "really well know for infants."

¶ 76 Carpenter testified that J.K. underwent at least two PFA tests. The first one, which occurred around March 31, 2012, was mildly elevated with respect to her response to epinephrine. However, the "ADP[4] cartridge was normal." Under such circumstances, "most hematologists would suspect that that was either a drug effect or a spurious result and would repeat it because that most of the time does not indicate a disease state." She would not make a diagnosis based on this result. A mildly relative response to epinephrine does not mean that J.K. had a bleeding or clotting disorder. She further stated that this result would not be a basis for concluding that J.K.'s platelets were marginally effective. In fact, the test was repeated a week or two later at Children's Memorial Hospital, and the results fell within a normal range.

¶ 77 On June 20, J.K. was also given a platelet aggregation assay test. This is a test for diagnosing (as opposed to screening for) platelet function abnormalities. Platelets are exposed to different agonists (triggers) "that make them clump" to see how they respond. Epinephrine is one agonist that is sometimes used. Not every lab uses it because it "is not as reliable of a diagnostic agonist as some of the other agonists." Carpenter continued, "[A] lot of the population has a variable response to [e]pinephrine or a low response to [e]pinephrine who don't have any bleeding disorder and so it can be confusing to include." Epinephrine was used in J.K.'s platelet aggregation assay. Moreover, no reference range was listed on J.K.'s test, which

[4] "ADP" stands for "Adenosine diphosphate." Stedman's Medical Dictionary 29 (27th ed. 2000).

Carpenter testified was necessary for a doctor to rely on the test results. However, a note from a doctor interpreting the result states that epinephrine was at 22%, but that was seen in normal individuals and should be considered a normal result. Carpenter found "two papers that describe reference ranges for [e]pinephrine and the result that [J.K.] had was within this range." She also called the laboratory that performed the test and spoke to a doctor there. He told her that they do not use a reference range for this test because "there are so many people who have [a] low response to [e]pinephrine [that] they didn't feel it was useful." Thus, Carpenter opined that this test also did not identify a coagulation disorder. Overall, J.K.'s lab results were normal. Nothing else in J.K.'s labs prior to her final admission to the hospital was a cause for concern. She further opined that, in the absence of continuing symptoms, further testing was not necessary and, finally, that J.K. did not have a bleeding disorder.

¶ 78 Carpenter also disagreed with Laposata that J.K. had a bleeding disorder from the time of her birth. She agreed with Laposata that a patient's history is important in forming a diagnosis. However, Carpenter would not expect to see bruising from mild traumas in either a normal infant or an infant with a mild platelet disorder. She added that even in nonmobile infants with severe hemophilia, she typically does not see much bruising because "they're babies in arms, they are not subject to trauma, they are not walking around, they are not crawling over toys." She would also expect medical treatment to cause more bruising than ordinary handling.

¶ 79 If a child presented to Carpenter with a history of bruising from things like lying on a pacifier or wearing a headband, she would initiate testing to look for severe bleeding disorders. Such tests were performed in this case. She testified that there is no correlation between low vitamin D levels and blood disorders. The bruises on J.K.'s body at the time of her death were not clinically significant to diagnosing a blood disorder; normal people bruise as well. Carpenter

had never heard of someone with a mild platelet disorder spontaneously develop an intracranial hemorrhage. Rather, she opined that some sort of trauma would have to be involved.

¶ 80 Some antibiotics—including penicillin and Amoxicillin—can make a bleeding disorder "slightly worse." She had prescribed such antibiotics to children with blood disorders because they do not have a significant enough of an effect to "change good treatment of whatever infectious disease you are dealing with." Carpenter was unaware of any property of Amoxicillin that affected how platelets were made. However, she stated that "Amoxicillin is not one that we focus on in terms of worrying about." Augmentin (for which Amoxicillin is the base), which was given to J.K. but stopped two weeks before her death, could not have contributed to her death in any way. Carpenter knew of no case where a person with a mild platelet dysfunction experienced an intracranial hemorrhage resulting in death as a result of being given antibiotics. Flagyl, which J.K. was given for a urinary tract infection shortly before her death, is not derived from penicillin. To Carpenter's knowledge, Flagyl has no impact on a blood disorder. Tylenol also does not, and she prescribes it regularly to children with bleeding disorders. Carpenter opined that, even in combination, the urinary tract infection, Flagyl, Augmentin, and Tylenol would not have had "any impact on" her death.

¶ 81 Platelet dysfunctions are treated with platelet transfusions. J.K. was given such a transfusion. After the transfusion, she decompensated and died. This indicated that the platelet transfusion did not help J.K. Carpenter explained that this treatment did not help her "for what should have been the proposed cause of her bleeding" as it should have if she had a bleeding disorder. Further, a heparin flush involves a small amount of heparin that "doesn't go into the bloodstream so to speak." It does not affect "clotting in the body in general."

¶ 82 A D-dimer is a "break down product of a clot." The body eventually breaks down clots because "we wouldn't want a clot just everywhere all of the time." Clots are formed from fibrin. The body "chops up the fibrin into pieces in order to break it down and those pieces are the D-dimer." This is a normal process in the human body. In fact, when a human body responds to a trauma, having elevated D-dimers is to be expected. Carpenter disagreed with Laposata that "elevated D-dimers make it hard to create a cellular clot." She stated that she had never heard this proposition before. Inflammation and stress can also elevate D-dimers. Carpenter would expect elevated D-dimers in a child with broken bones. Generally, elevated D-dimers would not be indicative of a blood disorder. Given J.K.'s condition at the time of her final admission to the hospital, Carpenter would expect J.K.'s D-dimers to be elevated at that time. Laposata's opinion that J.K.'s elevated D-dimers meant she was making clots but the clots were not working is not "scientifically sound."

¶ 83 Carpenter testified the DIC (disseminated intravascular coagulation) is a "derangement of the clotting system. DIC "doesn't stand alone"; rather, "it is caused by something else, be it trauma or infection or some other kind of cancer." Sepsis could cause it, but nothing in J.K.'s records indicated that she had sepsis. J.K.'s results on the PT and PTT tests (which are two screening tests for clotting that are "fairly nonspecific") were elevated, but that would be expected given J.K.'s condition at the time of her death. This did not mean she had a blood disorder. Combining abnormal PT, PTT and elevated D-dimers does not *cause* DIC, it "*defines* DIC." (Emphasis added.)

¶ 84 Carpenter disagreed that J.K. died from coagulopathy. She noted that a brain-death examination conducted on the day preceding J.K.'s death showed "dying neurons deep in her brain." There is no bleeding disorder that causes such an effect. Moreover, while she could rule

out a bleeding disorder as the cause of death, she could not rule out trauma. On cross-examination by DCFS, Carpenter stated that bone fractures are not related to blood disorders.

¶ 85 During cross-examination by respondents, Carpenter acknowledged that she did not read the entire transcript of Laposata's testimony. She could not recall various details of J.K.'s hospitalizations. However, she stated that knowing the precise history of where J.K. received treatment was not necessarily essential to forming a diagnosis. Carpenter was aware J.K. had a vitamin D deficiency in the summer of 2012; however, it had resolved by the time of her death. While a lack of vitamin D could cause someone to bruise, it does not affect how platelets function. Carpenter acknowledged that she had authored an article stating that a history of using or abusing medications could increase bleeding and bruising. She was aware that Jaclyn had Ehlers-Danlos syndrome and that it was a genetic disease. However, J.K. had been evaluated for it and not diagnosed with it. Carpenter wrote that petechiae could occur in nonmobile infants at "clothing line pressure sites." Her article also states that an intracranial hemorrhage can occur secondary to DIC. J.K. had DIC. J.K. was not given every test that exists to diagnose a bleeding disorder.

¶ 86 Carpenter agreed that the range she stated for normal platelet aggregation in response to epinephrine was actually the range for platelet secretion (a different process). She was not aware of a new article that placed the low end of the reference range for the platelet aggregation test at 38—J.K.'s was 22. If a patient had platelets that did not function properly, "one would be careful about what medications" one gave them. However, simply based on J.K.'s test result on the platelet aggregation test, Carpenter would not avoid giving her any particular medication. Carpenter agreed that a study had been recently conducted (of which she was not aware until the hearing) that purported to show acetaminophen can affect platelet function. Carpenter noted that

it was a small study. She also stated that if J.K. was taking Amoxicillin at the time of her platelet aggregation test, her actual baseline would be higher than the test result of 22. She agreed that given this result further testing, which was not performed, would have been warranted. For example, she might have repeated that test.

¶ 87 On recross-examination by the guardian *ad litem*, Carpenter testified that the medical tests performed on J.K. during her final hospitalization would result in bruises on a normal child. She would not have diagnosed J.K. with a bleeding disorder based on that single test result. A child with a mild platelet disorder from birth might exhibit bruising and bleeding, but it would not cause the sort of brain bleeds that lead to death.

¶ 88 On redirect-examination by the State, Carpenter testified that if J.K. had such a severe bleeding disorder that a brain bleed would spontaneously occur, she would expect to see bruising from the medical procedures (such as CPR) performed on J.K. However, J.K.'s medical records document no such bruising. The discrepancy between the range for the platelet aggregation test she used and the one published in the later study identified by respondents' counsel would not cause her to change her opinion, as a diagnosis of a platelet function disorder should not rest on a single test result. She also testified that blood is "not always evident on [a] CT or even an MRI initially."

¶ 89 Carpenter opined that J.K.'s intracranial pressure caused her DIC. She based this on J.K.'s clinical status, neurological status, the fact that her spinal tap had blood in it, and the fact that her "brain injury seemed out of proportion to the bleeding that was present." Ehlers-Danlos syndrome is not a blood disorder; vitamin D deficiency "is not a known cause of [a] bleeding disorder." She also opined that vitamin D deficiency does not cause bruising. Carpenter could find no connection between any of the conditions that affected J.K. at the time of her birth and

the causes of her death. During recross-examination by respondents, Carpenter admitted that the platelet transfusions J.K. received could have masked or inhibited marks from the spinal tab [*sic*] or another mark from an arm."

¶ 90 On December 29, 2014, after the reopening and closing of proofs, the trial court issued its second ruling in this case. The trial court stated that the reopening of proofs required it to go "back to the beginning" and re-review "all of the evidence in light of the new testimony." Nothing the trial court heard after the reopening of proofs changed its earlier weight and credibility assessments. It noted that what is known about J.K.'s death is that "she suffered from intercranial [*sic*] bleeding and intercranial [*sic*] pressure," and "a third event or stimulus" caused these conditions. Earlier, the trial court found, by a preponderance of the evidence, that the third event was trauma. The question, explained the trial court, is whether Laposata's testimony that J.K.'s death was caused by a bleeding disorder altered the balance of evidence such that "the cumulative evidence on the State's side is now less than the preponderance the State would need to meet their [sic] burden." It noted that Laposata and Carpenter agreed on many points, and the dispositive issue in this case is the one upon which they disagree.

¶ 91 The trial court acknowledged Laposata's extensive credentials. However, it further noted that the one article he published that concerned child abuse (pertaining to its over-diagnosis) "makes him more biased in favor of the parents in this case." The trial court emphasized that while Laposata "was credible," he was also "biased in favor of the parents."

¶ 92 Similarly, Carpenter's credentials were "also impressive and were unimpeached." While she has published fewer articles than Laposata, more of hers relate to "child abuse as it impacts her practice in hematology and coagulopathy." The trial court further observed that an article written by Carpenter concerned the misdiagnosis of child abuse in children know to have

bleeding disorders, which the trial court found enhanced her credibility by demonstrating she was aware of the "seriousness of getting it wrong." The trial court found Carpenter's error concerning the reference range for the platelet function test was "troubling." However, it observed that she made "no substantive errors regarding her knowledge of [J.K.'s] records." It also noted that Laposata also misstated a reference range. Moreover, Carpenter did not consider the test based on a platelet's response to epinephrine reliable. The trial court then stated that the error did not affect its assessment of Carpenter's opinion. While Laposata had practiced about 20 years longer than Carpenter, Carpenter's practice was focused on children with bleeding disorders. Thus, her experience was more relevant to this case. The trial court also stated that it found Carpenter "somewhat biased in favor of the State."

¶ 93 As for the substance of these experts' testimony, the trial court noted that Laposata opined that J.K. "had an undiagnosed bleeding disorder from birth based on the medical records he saw, which did include all of the labs, the history he read as well as a long conversation he had with mom in the fall or winter of 2013." In the conversation with Jaclyn, he learned "plenty of evidence [that had not been] brought to his attention." Notably, he learned that " 'basically wherever [J.K.] contacted anything, she had bruises.' " Laposata did not form his opinion until after this conversation. Essentially, Laposata opined that, given an undiagnosed bleeding disorder combined with Amoxicillin, Tylenol, and DIC, J.K.'s "big bleed could have been as a result of normal handling." As he had an explanation for J.K.'s bleeding, "he believed within a reasonable degree of medical certainty [that] J.K.'s cause of death was coagulopathy." Conversely, Carpenter opined that J.K. did not have a bleeding disorder and that, if she did, it was a mild one. A mild bleeding disorder, even combined with Amoxicillin, Tylenol, and DIC, would not have cause J.K.'s subdural hematoma.

¶ 94 Reviewing J.K.'s medical history, the trial court found that she was born with several problems; however, they "satisfactorily resolved within a week." At this time, J.K. was given Ampicillin, a penicillin derivative. There were no notes of bleeding or bruising despite various tests and procedures being performed. Subsequently, in February 2012, J.K. was hospitalized for MRSA and a respiratory virus. Again, no bleeding or bruising was noted, and the medical records make no reference to reports of bleeding and bruising by respondents or other care givers. On March 2, 2012, J.K. was seen at Sherman Hospital for a cough. The admission physical examination documented no bruising. A platelet function analysis performed on March 31, 2012, shows a "normal clotting response time to ADP; but to epi[nephrine], her time was 204 seconds, with a reference range of 89 to 190." During this period (March to May of 2012), respondents were documenting J.K.'s bruises by taking photographs (which are not in evidence). That J.K. had bruises to her facial area "does not appear to be in dispute." During a hospitalization on April 26, 2012, at Children's Memorial Hospital, Dr. Liker charted "[r]ed linear marks on bilateral internal upper thigh, multiple oval-shaped bruises to the mandible, right and left, marks and abrasions around the lips and on nose, blue-purple bruises to the mid-buttocks, right and left, red marks on the arm, blood at the upper frenulum and subconjunctival hemorrhage of the left eye." The trial court stated that it was not "suggesting that all those things appeared on [J.K.] all at one time."

¶ 95 On April 20, 2012, J.K. presented to Lutheran General Hospital. Respondents complained of bruising to and weakness of the right upper extremity and lip smacking. They said it had persisted for three days. J.K. remained in the hospital for three days, and no bruising, including in the area where a spinal tap was performed, was documented. On April 25, J.K. was admitted to Children's Memorial Hospital where she had "a battery of blood tests, all of which

were normal, including her second PFA." Outside of observations by respondents of spontaneous bruising following an MRI and a "faint mark to her nasal bridge," no other bruising was documented. It was during this hospitalization that the metaphyseal fractures were discovered. The trial court noted it was undisputed that a blood disorder did not cause the fractures.

¶ 96 On April 28, 2012, Dr. Goodell examined J.K. He observed a bruise on her cheek. He ordered additional blood testing and stated other testing "might be needed." J.K. was seen at Loyola on May 2, and no bruising was documented. On May 7, J.K. received shots, and no bruising was noted. Likewise, during medical procedures on June 20, no bruises were discovered. The court acknowledged that "bruise sheets dated June 21 to June 23 do note needle marks *** following the blood work that was done on June the 20th."

¶ 97 On July 12, 2012, Dr. Bordini diagnosed a vitamin D deficiency. Bordini's records do not note any bruising. On August 29, Dr. Tanna observed one bruise to each knee and to J.K.'s lower right leg. Respondents expressed no concerns at this time. On August 30, J.K. had a follow-up neurology examination. No bruises were noted, and Jaclyn stated that "the spontaneous bruising is getting much less frequent." On September 21, a pediatrician diagnosed J.K. with impetigo and prescribed Cephalexin and Bacitracin. No bruises were noted. On September 28, she again saw Bordini, who assessed her vitamin D level in the low-normal range. No complaints of bruising or bruises were charted as observed by Bordini.

¶ 98 On October 12, 2012, J.K. was seen at Sherman Hospital. Her impetigo had become a MRSA infection, and her antibiotics were changed to Augmentin and Bactrim. No bruises were noted. On October 22, J.K. saw her pediatrician. Augmentin was discontinued; Bactrim was continued. No bruises were observed. On October 26, J.K. again saw her pediatrician. She was

diagnosed with C. diff. All other antibiotics were discontinued and Flagyl was prescribed. Dr. Tanna observed linear marks on J.K.'s legs, which Kevin attributed to "a belt in a bouncer." The trial court found that "[t]here in fact are no straps or belts on that thing at all, and this statement to Dr. Tanna is not consistent with the argument at trial that the bruises were a result of repetitive trauma from the ring on the bouncer." On October 29, 2012, J.K. was admitted to the hospital for the final time. The trial court noted: "With all of the emergency treatment she got, including CPR from her dad, there was no remarkable bleeding, other than in her head, obviously." On J.K.'s admission, respondents "said that the bruising [had] in fact continued and gave an example that after she rolled over on a pacifier and fell asleep on one occasion, and then after falling asleep with her head against a crib bar on another occasion." The trial court explained that it could find nothing in the medical records indicating that respondents had ever stated that J.K. had bruises from laying on a pacifier (though respondents had recorded "marks" from a pacifier on bruise sheets dated August 24 and September 14).

¶ 99 Turning to the lab results, the trial court noted that J.K. had two platelet function tests. On the first one she had a slightly abnormal response to epinephrine and a normal response to ADP. On the second, both results were normal. These were screening tests, so the doctors, and in turn, trial court, placed little weight on them. On June 20, the platelet aggregation study was performed. The trial court stated that "[i]t was initially read by *** a pathologist, as an essentially normal PAS." J.K.'s blood was exposed to seven agonists. Her response to five of them was normal, in light of the reported reference ranges. No reference ranges were given for epinephrine and ADP. J.K.'s response to epinephrine was measured at 22. No treating doctors diagnosed her with a blood disorder based on this result. Both experts that testified regarded this test as the definitive test for diagnosing bleeding disorders.

The trial court emphasized that they were speaking of the entire test and not just the subportion of it based on response to epinephrine.

¶ 100 Laposata testified that a result of 22% was a significant abnormality, and he would have immediately developed a treatment plan. The trial court explained that this suggests "that the one abnormal result was diagnostic for [a] bleeding disorder." However, he also stated that this result could be seen in normal people. Further, Laposata said that the result alone would not have been conclusive diagnostically absent J.K.'s history of bruising.

¶ 101 Carpenter "was not concerned with this result even after she knew the correct reference range." This was because she did not regard epinephrine response as a reliable diagnostic agonist, as many otherwise normal people have a low response to this test. Some labs—including hers—do not even use the test. J.K.'s response had to be read in the context of the seven-part test as a whole, and all other results were normal.

¶ 102 The trial court credited Carpenter's testimony that bruising in a nonmobile infant with a mild bleeding disorder would not be expected. Anyone experiencing a spontaneous brain bleed "has a severe bleeding disorder by definition." It noted that J.K. experienced bruising from medical treatment on only two instances despite her extensive history of treatment (which included a "significant course of PT").

¶ 103 The trial court found that some of J.K.'s purported history on which Laposata based his opinion was not supported by the evidence in the case. Outside of reports from respondents, there is no evidence that J.K. had a bleeding disorder at the time of her birth. Jaclyn's statement to Laposata that J.K. bruised whenever she had contact with anything is not supported by the medical evidence. While it is true J.K. was given Amoxicillin from

October 12 to October 22, 2012, Laposata did not explain how J.K. could have been given penicillin for the first three days of her life without incident. The trial court further noted that while there is evidence that J.K. took Tylenol on the night of her final admission to the hospital, no evidence establishes that she took it "at all or at a dose or duration sufficient to have an impact on her prior to her admission." Laposata also failed to explain why J.K. had retinal hemorrhages of the type most commonly associated with nonaccidental trauma or why her condition failed to improve with a platelet transfusion.

¶ 104 The trial court then stated that neither Laposata nor anyone else explained how J.K. could have a bleeding disorder of such severity that it caused spontaneous bleeding into her brain but failed to have any other manifestations such as bruising from the invasive medical procedures to which she was subjected. The trial court then concluded, based on the entirety of the evidence and in light of its determinations regarding credibility and weight, its initial ruling should stand.

¶ 105 The cause then moved to a dispositional hearing, which was held on January 26, 2015. Brooke Plating, who was called by the State, was the sole witness to testify. She stated that she has been the caseworker for this matter since its beginning. A service plan for respondents recommended counseling. DCFS asked that it be individual counseling and communicated this to respondents in July 2012. Subsequently, respondents indicated that they were going to counseling with Beth Kowieski. Respondents were not referred to Kowieski by DCFS; rather, they found her through one of their friends. Plating spoke with Kowieski on July 22, 2012. She told Kowieski that DCFS wanted respondents to address the "medical explanation that had been given for [J.K.'s] injuries that she had sustained at that time (the fractures; J.K. had not died at this point), as well as the current legal proceedings and the police investigation that they were

under at the time." Plating had further communications with Kowieski. It appeared to Plating that rather than addressing the issues indicated by DCFS, prior to J.K.'s death they were addressing "their feelings regarding being involved in the DCFS system and the loss of their children from their custody." Subsequently, Plating stated, they were addressing the grief and loss they felt after J.K.'s death and the loss of the time they spent with B.K. DCFS was concerned that respondents were being jointly counseled and that Kowieski was not addressing the abuse that had occurred. Plating was also concerned about "boundary issues," as Kowieski had donated to "a crowd source funding website that had been established in the parent's name." Furthermore, her reports "read more like letters of recommendation for the family than therapeutic reports." Respondents changed therapists in June 2014 after being encouraged to do so by the trial court. Jaclyn now sees Deborah Perry; Kevin sees Angela Renee Brown. These therapists were selected through Jaclyn's employee-assistance program.

¶ 106 Plating spoke with Perry in August 2014. Plating explained that DCFS was involved because J.K.'s death was listed as a homicide and the agency wanted respondents to "process that in counseling, as well as the ongoing legal proceedings." Plating had a similar conversation with Brown at about the same time. Plating received a one page report from Perry and also had conversations with her. As to Jaclyn's progress, Plating stated: "She continues to process her grief over the loss of [J.K.], as well as the loss of her time with [B.K]. She continues to look for a medical explanation for [J.K.] death and appears adamant that [J.K.] died due to medical conditions." This was not satisfactory to DCFS, as it did not address "the fact that [J.K.] was abused." Perry reported that Jaclyn "was very devastated by the most recent court ruling and was not in a place where she could currently address that."

¶ 107 Plating also spoke with Brown. Brown reported that Kevin "remains adamant that his daughter died due to a medical diagnosis, but he understands why the most recent court ruling was made." As such, DCFS rated his progress in counseling as unsatisfactory, as "he is still not acknowledging that J.K. ever endured any abuse." Plating explained that if respondents could not acknowledge the possibility that J.K. was abused, it was not possible for DCFS to address the situation in their home that caused B.K. to be removed from it. No services could be put in place to correct this condition (*i.e.*, the occurrence of abuse) and protect B.K from similar danger. Respondents "have made statements to the effect that they believe they are the victims of a corrupt medical and justice system." Plating continued, "It would appear that their judgment is clouded as to why [J.K.] died."

¶ 108 Respondents underwent an assessment in July 2014 by a psychologist to which DCFS referred them. Jaclyn was not diagnosed with anything "that would form the basis of a task in the client service plan." Kevin, however, was diagnosed with depressive disorder and narcissistic personality disorder. The latter is concerning, Plating explained, because it causes him to internalize events. The evaluation further states that "he does not have the ability to empathize with others."

¶ 109 B.K. is currently placed with his maternal grandparents. He appears well adjusted, and it is "very obvious that he loves both of his grandparents." Plating has observed no behaviors by B.K. that are concerning. Previously, B.K. had undergone counseling from April 2013 to February 2014. At that time, he was having issues including an increase in tantrums, separation anxiety, and some sleep disruption. At the time of the dispositional hearing, B.K. was in counseling as he had "trouble transitioning to preschool." The grandparents reported that, when they dropped him off, he would "cry for a little bit before he would fall into the classroom

routine." Plating did not regard this as abnormal. Respondents also reported some behaviors in October 2014, but Plating could not recall what specifically they were. B.K. "seems to be doing well."

¶ 110 At the time of the hearing, visitation was occurring once a week, for three hours. B.K. and respondents also had "daily Facetime contact, as well as phone calls." Plating described the visits as "very affectionate, very age appropriate." Plating has never observed any behaviors that gave her "concerns about [respondents'] ability to parent." Nevertheless, DCFS had safety concerns, as J.K. died due to abuse.

¶ 111 Cross-examination by DCFS was conducted next. Plating testified that respondents' failure to acknowledge J.K.'s abuse was concerning in that it impacted on their ability to protect B.K. from similar abuse. Respondents have not acknowledged "even the possibility that somebody else had hurt" J.K. She explained that without appreciating that there is a risk to B.K., "it would be hard for them to be able to protect him from it." Without respondents' acknowledgment of abuse, there are no services DCFS could provide to the family.

¶ 112 On cross-examination by respondents, Plating acknowledged that she had not spoken with either therapist (Perry or Brown) in the two weeks preceding the dispositional hearing. On January 25, 2013, Plating drafted a service plan that included the recommendation that Kevin process the medical explanation of J.K.'s death. She was not sure whether the plan included a specific request for respondents to engage in counseling individually. In April 2013, Plating rated respondents as satisfactory in all domains except in obtaining a mental health assessment. She agreed that shortly thereafter, respondents agreed to undergo such an assessment. In April 2014, Plating again rated respondents unsatisfactory in processing the medical explanation of J.K.'s death. As for the diagnosis of narcissism, Plating agreed that the doctor stated that "it

could lead to him injuring himself." Regarding danger to B.K., Plating testified, "It would raise a concern if he took the child's actions personally as them doing something to upset him." However, she agreed that the psychological report also states that "there is no indication that he would have any difficulty in self-regulation, judgment, or impulse control." She acknowledged that both respondents scored "rather well" on an instrument know as the Child Abuse Potential Inventory (CAPI). Moreover, the psychological evaluation indicated that respondents were evaluated as having "significant protective factors." If respondents were to acknowledge J.K. was abused, DCFS "could create a service plan to provide services that would prevent that from happening again."

¶ 113 On redirect-examination, Plating testified that neither of respondents had ever expressed that J.K. was killed. All services in a client service plan do not carry the same weight. Rather, the most significant task is addressing the reason the case came into care. In this case, Plating explained, it was J.K.'s abuse. Plating stated that DCFS could not rely on the results of the CAPI evaluation and the fact that respondents were evaluated to have significant protective factors because J.K. was killed while in respondents' care. Quite simply, these protective factors were present when J.K. died as a result of what happened in their home. Plating would have concerns about respondents' sincerity if they now said they believed J.K. was abused.

¶ 114 The Guardian *ad litem* then conducted cross-examination of Plating. Plating testified that this case initially came to the attention of DCFS because J.K. had "bilateral distal femoral metaphyseal corner fractures or what are commonly known as bucket fractures." The staff at Children's Memorial Hospital determined that they were consistent with non-accidental trauma. At that time, there was also concern regarding "rib fractures in varying stages of healing." Plating was present when the case was placed on pre-adjudicatory supervision. Respondents

agreed to participate in certain services, which included recognizing that J.K. had been abused (here referring to the fractures that were the subject of the stipulation that led to the order of pre-adjudicatory supervision). Nevertheless, at that time, respondents were insistent that J.K.'s fractures were the result of a medical condition rather than abuse.

¶ 115 The trial court begin its ruling by noting that it was the law of the case that, in April 2012, J.K. was diagnosed with bilateral leg fractures arising from nonaccidental trauma. Nonaccidental trauma, continued the trial court, is abuse. The perpetrator was unknown, and respondents were placed on pre-adjudicatory supervision. In December 2014, a finding of neglect was entered. The trial court noted that it had twice found (before and after the motion to reopen proofs) that "someone hurt [J.K.]." She suffered from abusive trauma to her head that led to her death.

¶ 116 The trial court then stated that, "based on the very significant injuries to [J.K.] essentially spanning her entire lifetime, I first find that it is in [B.K.'s] best interest that he be made a ward of this court." It then found that the fact that respondents "continue to maintain that all of [J.K.'s] injuries were the result of medical conditions, that makes them unfit." Having found respondents unfit, it placed custody and guardianship of B.K. with DCFS. The trial court emphasized to respondents that its ruling was final and that medical issues concerning J.K.'s death would not be revisited. The trial court also kept the permanency goal set at return home within 12 months. Respondents now appeal.

¶ 117 III. ANALYSIS

¶ 118 Respondents contend that the trial court erred in finding that they violated a term of pre-adjudicatory supervision.[5] They also contest the trial court's ruling that they are unfit parents and that it was in B.K.'s best interests for his custody and guardianship to be placed with DCFS. These issues present questions of fact subject to review under the manifest-weight standard. *In re Jaron Z.*, 348 Ill. App. 3d 239, 259-60, 261-62 (2004). Therefore, we will reverse only if an opposite conclusion is clearly apparent. *In re R.S.*, 382 Ill. App. 3d 453, 459 (2008). On appeal, it is the burden of respondents, as the appellants, to establish that the trial court erred. *McGann v. Illinois Hospital Ass'n, Inc.*, 172 Ill. App. 3d 560, 565 (1988).

¶ 119 A. THE PETITION TO REVOKE PRE-ADJUDICATORY SUPERVISION

¶ 120 Respondents begin their argument by pointing out that all but one of the State's allegations claim that they engaged in some act or omission that led to J.K.'s death. Specifically, the State alleged (1) respondents "did not provide all necessary care to [J.K.] in that she died of non-accidental injuries while in the care of Mother and/or Father"; (2) respondents "engaged in acts of commission that tend to make the home not a proper place for [B.K.] in that [J.K.] died of unexplained nonaccidental injuries"; (3) respondents "engaged in acts of omission that tend to make the home not a proper place for [B.K.] in that [J.K.] died of unexplained nonaccidental injuries"; and (4) respondents "did not ensure proper supervision in that that [*sic*] [J.K.] died of unexplained nonaccidental injuries." The State also alleges that respondents did not give DCFS notice as required of the bruises on J.K.'s legs. However, as respondents note, this latter requirement applied only for injuries requiring medical treatment, and there was no evidence that these bruises were of that

[5] Respondents persistently fail to provide pinpoint citation to the legal authority upon which they rely; citing the actual pertinent pages of a case would remove any ambiguity and be helpful to the court in understanding respondents' arguments.

magnitude. Respondents then reason that since all of the other conditions relate to J.K.'s death, the State was required to show a causal relationship between the act alleged and J.K.'s death. We agree with respondents on this point.

¶ 121 Respondents then correctly state that an expert's opinion is only as valid as the reasons or bases for it. *In re Monica S.*, 263 Ill. App. 3d 619, 626 (1994). Respondents then cite a number of cases that address the *Frye* doctrine. See *Donaldson v. Central Illinois Public Service Co.*, 199 Ill. 2d 63, 75-88 (2002); see also *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923). This doctrine concerns the admissibility of new or novel scientific evidence. *In re Commitment of Simons*, 213 Ill. 2d 523, 529-30 (2004). We note that a *Frye* objection is forfeited if it is not raised in a timely manner before the trial court (*Snelson v. Kamm*, 204 Ill. 2d 1, 25 (2003)), and it does not appear that respondents interposed such an objection at any point during the proceedings below. In any event, as the issue before us concerns the weight rather than the admissibility of the various expert opinions presented to the trial court, *Frye* and its progeny provide little guidance here.

¶ 122 Instead, we look for guidance in the well-developed principles by which courts of review evaluate a trial court's assessment of evidence. On factual matters, we owe the trial court considerable deference. *In re Marriage of Quindry*, 223 Ill. App. 3d 735, 737 (1992). Assessing the credibility of witnesses, resolving conflicts in their testimony, and assigning weight to evidence are primarily matters for the trial court. *Bernstein & Grazian, P.C. v. Grazian & Volpe, P.C.*, 402 Ill. App. 3d 961, 976 (2010). We reject respondents' assertion that "assuming [the State's experts' methods] are generally accepted in the fields of forensic pathology and related fields, any deviation from that methodology would render any conclusions medically and scientifically untenable." Respondents cite no legal authority in support of this proposition, most

likely because this is not the law. It is axiomatic that any defect in the basis of an expert's properly-admitted opinion is a matter affecting the weight to which it is entitled. See *In re L.M.*, 205 Ill. App. 3d 497, 512 (1990); see also *In re Commitment of Walker*, 2014 IL App (2d) 130372, ¶ 74.

¶ 123 In light of these standards, we cannot conclude that an opposite conclusion to the trial court's is clearly apparent. Quite simply, both sides marshaled considerable evidence in support of their respective positions. The evidence was conflicting, and the trial court determined that the State's experts were more persuasive than respondents' experts. Having reviewed the record in its entirety, we cannot say that respondents' experts were so persuasive and the State's experts so wanting that the trial court could not accept the State's experts' testimony.

¶ 124 Nevertheless, respondents argue that a different result should obtain. They begin by noting that the State's experts identified two methodologies doctors use for diagnosing medical conditions: the differential-diagnosis approach and the evidence-based medicine approach. According to respondents, Dakil purported to use the former while Carpenter subscribed to the latter.

¶ 125 1. Differential Diagnosis

¶ 126 Respondents first address the differential-diagnosis approach. Carpenter (who explained both approaches) explained that under this approach, a list of potential diagnoses is developed based on what rationally fits the condition of a particular patient. Doctors then order tests to confirm or rule out particular potential diagnoses. Dakil stated that she diagnosed child abuse by a process of elimination. She eliminated other reasons for the "constellation of injuries" she observed in J.K. However, she clarified that her diagnosis was based on cerebral edema, retinal

hemorrhaging, and bruising (presumably she was referring to the pattern bruising at this point). Helenowski testified in a similar manner.

¶ 127 Respondents contend that child abuse was classically diagnosed with reference to a "constellation of injuries formerly referred to as the 'triad' [which] included retinal hemorrhaging, subarachnoid or subdural hemorrhaging and cerebral edema." See Jay Simmons, *Ironic Simplicity: Why Shaken Baby Syndrome Misdiagnoses Should Result In Automatic Reimbursement For The Wrongly Accused*, 38 Seattle U. L. Rev. 127, 127-38 (2014). However, Dakil testified that with only two of these three classic symptoms manifesting in J.K., she would still diagnose child abuse. This evidence and testimony was presented to the trial court, and it was for the court to assess its effect on the weight to which Dakil's opinion was entitled. *Lovelace v. Four Lakes Development Co.*, 170 Ill. App. 3d 378, 384 (1988) ("It is the opponent's responsibility to then challenge the sufficiency or reliability of the basis for the expert's opinion during cross-examination, and the determination of the weight to be given the expert's opinion is left to the finder of fact."); see also *Brewer v. Custom Builders Corp.*, 42 Ill. App. 3d 668, 677 (1976) ("The relative weight and sufficiency of expert and opinion testimony in a given case is peculiarly within the province of the trier of fact to decide."). Dakil explained that having two of the three symptoms in light of J.K.'s history was "highly concerning." It was for the trial court to assess what the absence of one of the three symptoms of the triad had on the weight to which Dakil's testimony was entitled.

¶ 128 Respondents note that "a very important and missing part of that constellation of injuries was the existence or non-existence of a subdural hematoma, as well as the timing of its emergence." We note that the evidence on this issue was conflicting. Dakil, Helenowski, and Carpenter all testified that a subdural hematoma could be masked on various imaging scans, such

as an MRI. Dakil believed the subdural hematoma was present at the time of J.K.'s final admission to the hospital. Conversely, Bryant opined that trauma did not cause J.K.'s death as there were no external injuries. Abern testified that it was extremely unlikely that imaging scans would miss a subdural hematoma. Resolving such conflicts in the evidence is primarily a matter for the trier of fact (*Bernstein & Grazian, P.C.*, 402 Ill. App. 3d at 976), and we perceive nothing in the record that would render it such that the trial court could not credit the State's three experts who agreed that a subdural hematoma could be masked. Likewise, evidence concerning retinal hemorrhaging was conflicting, and there was testimony that the nature of J.K.'s retinal hemorrhaging was consistent with child abuse. Dakil explained that while it was possible for a retinal hemorrhage to result from intercranial pressure, the distribution of hemorrhaging in J.K.'s eyes was not consistent with such a cause. The pattern in J.K.'s eyes was diffuse rather than being limited to the area around the optic nerve, which is more consistent with trauma. Again, given the state of the record, this was a matter for the trial court. Respondents make other similar attacks upon the bases of the State's experts opinions, but we find none so persuasive that we could say that an opposite conclusion is clearly apparent to the position taken by the trial court.

¶ 129 In addition to attempting to undermine Dakil's opinion, respondents also advance an alternate diagnosis as a cause of J.K.'s death (*i.e.*, a competing, differential diagnosis). The only competing diagnosis for which significant evidence exists in the record is a coagulation disorder (there was ample testimony from which the trial court could conclude that other diagnoses such as a Vitamin D deficiency or Ehlers-Danlos syndrome had been ruled out). However, given the state of the record, we cannot say that it is clearly apparent that a coagulation disorder caused J.K.'s death. For example, Carpenter's testimony, in itself, provides an ample basis for ruling out a coagulation disorder. Most saliently, if J.K. had a bleeding disorder of sufficient magnitude to cause a spontaneous bleed into her

brain, there should have been some other significant manifestations of that disorder near the time of her death. She also noted that J.K. had a platelet transfusion to which she did not respond. Carpenter would have expected her to respond to this treatment if she had a platelet disorder. Elevated D-dimers show that J.K. was forming clots and breaking them down—a natural process. Moreover, Carpenter's testimony provides a basis to reject Laposata's. She disagreed with him on several points, including the interpretation of J.K.'s lab results, that J.K. had a bleeding disorder from the time of her birth, and that Tylenol would contribute to a bleeding disorder (we note that Dakil also testified that Flagyl does not cause intracranial pressure). While Laposata had been practicing longer, the trial court could have concluded that Carpenter's testimony was entitled to more weight, given that she focused on pediatrics.

¶ 130 In sum, none of respondents' criticisms of the bases of the opinions of the State's experts is sufficient for us to say that the trial court's decision to accept them over respondents' experts is contrary to the manifest weight of the evidence.

¶ 131 2. Evidence-Based Medicine

¶ 132 Respondents next take issue with Dr. Carpenter's invocation of evidence-based medicine. She described this as "the practice of providing care and making diagnoses on the best available and most up-to-date evidence and evidence being data which is accumulated through studies." She continued:

> "So when you do evidence based medicine, you have to rely on the data that is available. You can't hope that there may be other data that will prove you right some day. You have to—and that is what they mean by the best and up-to-date.
>
> You also have to make sure you are up-to-date and not out of step with what is current. So knowing the best medicine to give someone, for instance, you have to be able

> to look at what studies have shown those medicines, not necessarily what is better in that scenario.
>
> Diagnosis, same kind of thing, there is criteria for that are good studies in terms of what a diagnosis is and it is not just a case report that something may have happened some time. It has to be a systematic view where either a number of cases have been accumulated or there are biological aspects that."

Respondents contend that Carpenter did not adhere to her own professed methodology.

¶ 133 Interestingly, after setting forth the methodology espoused by Carpenter, respondents then focus on Dakil's opinion, despite the fact that in the previous section of their argument, they asserted that Dakil "seemed to follow a version of the 'differential diagnosis' model." Moreover, their analysis of Dakil's opinion is flawed. Essentially, they assert that Dakil testified that violently shaking a baby most likely would impact the spinal cord and nerve root. However, she also testified that it was possible to shake a baby hard enough to cause brain damage without inflicting injury upon the neck muscles. Respondents criticize Dakil for not providing studies in support of this latter claim. However, Dakil was recognized as an expert in the areas of pediatrics and child-abuse pediatrics. It simply would not be realistic for an expert to produce a study for every item of knowledge they have acquired in the course of becoming an expert. Rather, this was an appropriate subject for cross examination. See *Melecosky v. McCarthy Brothers, Inc.*, 115 Ill. 2d 209, 216 (1986) (holding that typically, an expert may determine what is the proper basis for his or her opinions, and it is then up to the opponent to cross examine the expert on that basis).

¶ 134 Respondents make much of the absence of any sign of trauma to the outside of J.K.'s head. Initially, we note that this would not be surprising in a shaken baby case. Dakil testified that external signs of trauma might not be present. On this testimony, respondents state, "Instead of accepting evidence that even a layperson can fully understand ***, we are asked to consider Dr. Dakil's

preposterous explanation that an external blow to an infant's head sufficient to cause her death may not cause damage or a fracture to the skull because the force can be spread through the skulls [*sic*] suture lines." We find this assertion ironic and perhaps a bit disingenuous. Earlier, in decrying the trial court's ability to sort through complex medical evidence, respondents asserted that "science is oftentimes counterintuitive and most judges and lawyers are not well trained in scientific methods." Are we to reject an expert's reasoned explanation based on these things "even a layperson can fully understand" even though "science is oftentimes counterintuitive?" Indeed, if Dakil's opinion was a dubious one, it should have been addressed by respondents on cross-examination and ruled on by the fact finder.

¶ 135 Respondents again raise the issue of the imaging scans not finding the subdural hematoma at the time of J.K.'s final admission; however, three experts testified that this could happen, and Dakil explained the mechanism by which it could occur. They further assert that the trial court should have accepted Bryant's testimony about external trauma over Dakil's, but fail to explain why Bryant's testimony is so persuasive as to render the trial court's decision against the manifest weight of the evidence.

¶ 136 Perhaps most significantly, respondents point to Carpenter's failure to use the proper reference range to interpret J.K.'s platelet aggregation study. However, Carpenter explained that, while she might have repeated the test, "a single agonist abnormality is not diagnostic of a platelet function abnormality." As a single deviant result is not a basis for diagnosing an abnormality, the trial court could have concluded that Carpenter's oversight did not materially affect the weight of her opinion.

¶ 137 Again, while respondents identify some defects in the State's experts opinions and conflicts in the record between the various expert witnesses, none are so compelling as to render the trial court's ruling contrary to the manifest weight of the evidence.

¶ 138 3. Nonaccidental Trauma or an Organic Cause

¶ 139 In the next two sections of their brief, respondents argue that the State failed to prove that J.K. died as a result of nonaccidental trauma and that they proved that she died as the result of a blood disorder. The former argument is largely a rehash of their earlier arguments, and we find them no more persuasive in this context.

¶ 140 As for the latter contention, they first point out that Carpenter shared Laposata's concerns that blood disorders were sometimes misdiagnosed as child abuse. Carpenter also testified that blood disorders tend to be inherited and that a mild platelet order will not go away by itself. She also testified that blood disorders tend to present in babies.

¶ 141 Abern testified that, based on his review of J.K.'s medical records, she had problems with coagulation (we note that the trial court expressly found Dakil entitled to greater weight than Abern). Laposata opined that J.K. had an unnamed bleeding disorder. Citing her neonatal ecchymosis, he believed it was inherited. Laposata noted her response to epinephrine was low on one test. Carpenter agreed (after her attention was called to further studies) that this result was low. Carpenter also agreed that a person with a mild blood disorder could have "occasional spontaneous bleeding," "depend[ing] on the type of disorder."

¶ 142 Laposata testified that because of her purported bleeding disorder, it would have been important to make sure J.K. did not take anything that would reduce the effectiveness of her platelets. He believed that Tylenol, Amoxicillin, and antibiotics could exacerbate J.K.'s bleeding disorder. In fact, J.K. had taken Tylenol and Amoxicillin (she also had taken Flagyl, which Dakil testified would have no effect on her coagulation). However, countervailing evidence exists in the record. Carpenter testified that Tylenol is her pain reliever of choice for children with bleeding disorders. Respondents claim that Carpenter later conceded Tylenol could adversely affect coagulation. In fact, she testified, after being presented with an abstract of what she termed a "small study," that the study

indicates that it is "possible" that Tylenol cold affect coagulation. On redirect-examination, she explained that the study, which involved six healthy adults, would need to be confirmed by a larger sample group. She then added that she has never had an issue with Tylenol making bleeding worse. Carpenter also testified that even if J.K. had a mild bleeding disorder, taking Amoxicillin and Tylenol would not exacerbate it to the point where she would spontaneously experience a subdural hematoma.

¶ 143 Respondents' claim that they proved an organic cause of J.K.'s death might be well founded only if one were to accept the testimony of their witnesses and reject that of the State's experts (of course, the trial court did not). For example, in interpreting J.K.'s elevated D-dimers, Laposata testified that this showed that J.K. was trying to form clots, but they were breaking down, while Carpenter opined that this showed that J.K. was clotting in response to the subdural hematoma and other injuries and some of the clots were breaking down as a result of the natural processes of the body. Resolving such factual disputes is for the trial court (*Bernstein & Grazian, P.C.*, 402 Ill. App. 3d at 976); given this conflicting evidence, we certainly cannot say that an opposite conclusion is clearly apparent.

¶ 144 While respondents have been able to point to some conflicts in the evidence and raise credibility issues, none are so significant as to allow us to reverse the decision of the trial court.

¶ 145 B. Fitness And The Minor's Best Interests

¶ 146 Respondents next contend that the trial court's decisions that they are unfit parents and that it was in B.K.'s best interests that he be made a ward of the court are against the manifest weight of the evidence. See *In re Julian K.*, 2012 IL App (1st) 112841, ¶ 86. We will disturb these decisions only if an opposite conclusion to the trial court's is clearly apparent. *In re R.S.*, 382 Ill. App. 3d at 459. Respondents also raise constitutional issues, which we review *de novo*. *In re A.W.*, 231 Ill. 2d 92, 106 (2008).

¶ 147 The issue here is rather narrow. Respondents have a stable home and are gainfully employed. Their interactions with B.K.—as observed by their caseworker—were age appropriate and affectionate. Respondents were engaged in counseling where they were addressing their grief. Respondents scored well on actuarial instruments, which indicated that they were not likely to commit child abuse and that they had significant "protective factors." The point of sole contention was respondents' refusal or inability to process the fact that J.K. died as a result of abuse (though Kevin did understand and articulate the basis for the trial court's ruling).

¶ 148 Plating testified that respondents' failure to acknowledge J.K.'s abuse was concerning because it impacted on their ability to protect B.K. from similar abuse. Respondents would not accept "even the possibility that somebody else had hurt" J.K. Without appreciating that there is a risk to B.K., "it would be hard for them to be able to protect him from it." Moreover, there were no services DCFS could provide to the family. Plating's testimony provides ample factual support for the trial court's findings.

¶ 149 Respondents complain that the trial court stated that it was the law of the case that J.K. had been abused. Citing due process concerns, they question how such a finding could be entered, given that abuse had never been pleaded. See *In re J.M.*, 170 Ill. App. 3d 552, 565 (1988) (overruled on other grounds by *People v. R.G.*, 131 Ill. 2d 328, 341-42 (1989)). However, the instant case is about B.K., so it is not immediately apparent how a pleading pertaining to J.K. is relevant. Indeed, respondents do not provide a citation to that pleading, and we have not located it in the record (apparently it was part of the closed, companion case concerning J.K.). We do note, however, that in admonishing respondents, the trial court stated, "What is before me this afternoon are two things, whether there is—there is probable cause to believe that your children are abused and/or neglected as has been alleged in these petitions, which describes or alleges [*sic*] at this point what appears to be

non-accidental injuries to [J.K.], *those would be abuse counts to [J.K.]*." (Emphasis added.) Thus, as best as we can tell from the record before us, abuse was alleged as it pertained to J.K., and what the trial court stated was the law of the case pertained to J.K.

¶ 150 Moreover, even a casual reading of the trial court's ruling indicates that it was noting that J.K. was abused as a matter of fact:

> "The law in this case is that in April 2012 [J.K.] was diagnosed with bilateral leg fractures due to nonaccidental trauma. The parents stipulated to that fact on July 31, 2012. And based on that fact that [J.K.] actually had abusive fractures, there was a further stipulation that [B.K.'s] environment was injurious to his welfare because of the injuries to his sister."

We also note that respondents have appeared and participated without an objection to notice in this proceeding, thereby forfeiting this point. *In re J.W.*, 87 Ill. 2d 56, 62 (1981) ("The mother had actual notice of the charges against her son and the correlative threat to her own rights; she appeared in court and participated actively in the proceedings without objection."). Indeed, the State pleaded, *inter alia*, that J.K. "sustained injuries of a non-accidental nature, specifically bone fractures." It repeated the allegation citing bruises instead of fractures. Respondents stipulated to the basis for these allegations. How respondents were not adequately advised of the nature of the proceedings is not apparent. In short, we do not find this argument persuasive.

¶ 151 Respondents also assert that their fifth amendment rights are being violated. The fifth amendment right against self incrimination applies in proceedings such as this one. *In re L.F.*, 306 Ill. App. 3d 748, 753 (1999) ("The fifth amendment privilege not only permits a person to refuse to testify against herself during a criminal trial in which she is a defendant, but also allows her to refuse to answer questions put to her in any other proceeding, civil or criminal, where the answers might tend to incriminate her in future criminal proceedings."). Respondents assert that the trial court is

requiring them to admit criminal culpability at the pain of losing their parental rights. They cite a number of cases in support. In *In re A.W.*, 231 Ill. 2d 92, 108 (2008), our supreme court held that "a trial court may order a service plan that requires a parent to engage in effective counseling or therapy, but may not compel counseling or therapy requiring the parent to admit to committing a crime." However, the third district explained that "there is a very fine but important distinction between taking steps to terminate a parent's rights based specifically on a refusal to waive a right against self-incrimination and doing so based upon a parent's failure to comply with an order for meaningful therapy." *L.F.*, 306 Ill. App. 3d at 753. In *A.W.*, 231 Ill. 2d at 108, the supreme court found no violation because: "[I]t is undisputed that the circuit court did not specifically require [the respondent] to admit any wrongdoing. The circuit court did not order [the respondent] to complete a specific program requiring him to admit abuse." In this case, respondents are not being asked to admit that they abused J.K. or that they are legally responsible for her death (in accordance with *A.W.*, 231 Ill. 2d at 108, respondents cannot be required to admit committing a crime, whether directly or through an accountability theory); they are simply being asked to acknowledge that J.K.'s death was the result of abuse by someone. Respondents do not explain how that would amount to an admission of criminal culpability.

¶ 152 Respondents complain that requiring them to acknowledge the cause of their daughter's death "smacks of a totalitarian approach to indoctrination rather than an accepted part of our legal system." We vehemently disagree. The nexus between respondents acknowledging the cause of J.K.'s death and their ability to protect B.K. from a similar danger is obvious. Quite simply, if they refuse to accept that this is a potential danger, they cannot take steps to guard against it. It is true that outside of the fact that respondents refuse to acknowledge J.K.'s abuse, there is nothing else to indicate that they are unfit. However, respondents refusal to recognize this potential danger is a substantial consideration. After the initial incident of abuse (leg fractures), there was no other evidence that

indicated that respondents were unfit; nevertheless, J.K. died. Based upon our review and consideration of the totality of the evidence, we cannot say that the trial court's decision to accord significant weight to this consideration is contrary to the manifest weight of the evidence.

¶ 153 IV. CONCLUSION

¶ 154 In light of the foregoing, the judgment of the circuit court of Kane County is affirmed.

¶ 155 Affirmed.