No. 923-2011

IN THE STATE OF WHITTIER SUPREME COURT

David SMITH,
Appellant
v.

STATE OF WHITTIER,
Ms. Kathryn Candler, Director of the Whittier Department of Child Welfare,
Appellee

ON APPEAL FROM THE

STATE OF WHITTIER COURT OF APPEAL

BRIEF FOR THE APPELLEE

Team 104
January 6, 2012

Counsel for Appellee

QUESTIONS PRESENTED

1. Was the Juvenile Court's finding that Olivia Smith was a dependent child and subsequent order terminating parental rights proper?
2. Did the administration of psychotropic medication to Olivia Smith, a child in foster care, constitute ordinary medical care under the Whittier Juvenile Code?

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OPINIONS BELOW

The unreported opinion of the State of Whittier Court of Appeal appears on page 7-12 of the record. *Smith v. Whittier* (Whit. Ct. App. 2011).

JURISDICTIONAL STATEMENT

The Supreme Court of Whittier is the highest court in the state of Whittier. Therefore, it may hear all cases of the Whittier state courts, and its decisions are binding on all other Whittier state courts.

STATEMENT OF THE CASE

PRELIMINARY STATEMENT

This case was filed by David Smith appealing the Jennings County Juvenile Court's finding that his child, Olivia, is a dependent of the Juvenile Court pursuant to Whittier Juvenile code § 100(b), due to medical neglect and specifically childhood obesity, and the subsequent termination of his parental rights pursuant to § 200 of the Whittier Juvenile Code. R. at 1. Appellant also appeals the Juvenile Court's finding that the Department of Child Welfare's administration of psychotropic medication to Olivia constituted ordinary medical care pursuant to § 300(c)(i) of the Juvenile Code. R. at 1. The Whittier Court of Appeals upheld the Jennings County Juvenile Court's findings, and the Appellant filed an appeal to this court. R. at 1. Appellant, David Smith, was granted certiorari to the Supreme Court of Whittier. *Smith v. Whittier* (Whit. Ct. App. 2011), *cert. granted*, (Whit. November 18, 2011) (No. 923-2011).

STATEMENT OF THE FACTS

Olivia Smith, an eleven-year old girl has been raised by her father David and grandmother, Greta, since her mother died in childbirth. R. at 1. David works the night shift at a 24-hour gas station, and Greta cares for Olivia when David is working. *Id.* Although David does take Olivia to the county health clinic for yearly check-ups, he has never followed the treatment advice that doctors have given him regarding Olivia's most serious health condition – obesity. R. at 2. At each of Olivia's yearly health exams, doctors warned David that Olivia's obesity and continual weight gain put Olivia at risk for immediate and lifelong health issues. *Id.* David disregarded multiple suggestions on how to improve Olivia's diet and increase her physical activity, claiming that Olivia was "just fine" and would grow out of her weight problem. *Id.* Olivia's diet consisted of junk food that David brought home from the gas station, free

lunches she received as part of a school program, and the traditional southern foods that Greta cooked for Olivia. *Id.* In 2008, at age eight, Olivia weighed 100 pounds and Dr. Masters, Olivia's pediatrician, told David that Olivia was morbidly obese, with a body mass index (BMI) of 30. *Id.* Due to her obesity, Olivia had trouble walking and joint pain, along with hyperlipidemia and impaired fasting glucose, putting her at a higher risk for both type-2 diabetes and cardiovascular disease. *Id.* Tests also showed that Olivia had liver disease that had neared a life-threatening stage and was at immediate risk for other life threatening conditions – sleep apnea with cardio-respiratory compromise and polycystic ovarian syndrome. *Id.* Dr. Masters warned David of the serious nature of these conditions, but also told David that if Olivia lost weight, the risk of those health conditions would be significantly reduced. *Id.* She gave David directions to put Olivia on a healthy diet and enroll Olivia in sports activities at the nearby YMCA four times a week, and scheduled a follow-up appointment for six months later, warning David that the child welfare system may intervene if Olivia's weight did not improve. *Id.*

David attempted to change Olivia's diet, but she did not like it, so he quickly gave up. R. at 3. In addition, David took Olivia to the YMCA, but was limited to two classes per week due to transportation issues. *Id.* As a result, by the six-month follow-up appointment, Olivia had gained ten pounds. *Id.* David was again warned of the possibility of state intervention, and Dr. Masters gave David more instructions for improving Olivia's weight and scheduled Olivia for a follow-up appointment one month later in addition to putting in an order for a nurse to make weekly home visits. *Id.* David avoided the appointments that the county nurse made with him as well as the follow-up appointment with Dr. Masters, forcing Dr. Masters to contact the Department of Child Welfare to report David's medical neglect of Olivia. *Id.*

When Sonia, the social worker, arrived at David and Olivia's apartment to meet with

Olivia, she discovered that Olivia was failing most of her classes and hated going to school. *Id.* Sonia also discovered that Olivia was regularly bullied by the other students due to her weight, and was even found crying in the school bathroom. *Id.* Sonia explained that a hearing would be held in a month to determine whether Olivia was a neglected child. By the hearing, Olivia had not lost any weight, and David had not made any healthy changes to her lifestyle. R. at 4. The juvenile court found that Olivia was a neglected child and removal from the home and foster care was in Olivia's best interest. *Id.* The court also ordered that David attend parenting and nutrition classes and allowed David unsupervised visitation every other weekend. *Id.*

Olivia's placement with the foster family was initially successful. *Id.* Olivia got along well with the other foster child in the home and with her foster parents; she began eating well, became much more active, and lost ten pounds within three months. *Id.* However, four months into the placement, Olivia began exhibiting serious behavioral problems, including acting violently toward her foster mother and other children at summer camp and banging her head on the floor. *Id.* After finding Olivia crying in the closet and determining that Olivia missed her father, Olivia's foster mother contacted Sonia and told her that Olivia seemed depressed. *Id.* After a consultation with a child psychiatrist, Olivia was diagnosed with depression and bipolar disorder. *Id.* The psychologist prescribed two medications for Olivia (after conducting precautionary medical tests), which Sonia signed off on and Olivia began taking. *Id.*

During visitation, David noticed that Olivia seemed sedated, and Olivia told him that the medication made her feel tired. R. at 5. David told Sonia that he didn't approve of the medications and wanted them stopped, but Sonia informed David that the medical consent form that he had signed allowed for Olivia to be given the medication at the Department of Child Welfare's consent and that he must raise any objections at the next six-month hearing. *Id.*

At the six month hearing, the court found that Olivia's health had greatly improved and that David had attended all of his parenting and nutrition classes as well as his scheduled weekend visits. *Id.* The court released Olivia back into David's care on the condition that he continued the lifestyle changes that had improved Olivia's health and that he report to a nutritionist for regular weigh-ins. *Id.* However, when Sonia conducted home visits, she realized that David did not help Olivia maintain a healthy lifestyle, and that he did not report to the nutritionist for the weigh-ins. *Id.* At the next hearing, the court again removed Olivia from David's care due to her weight gain and still existing health conditions and placed her back with the Fishers. *Id.* Olivia's behavioral problems resurfaced once back in foster care because she had stopped taking the medication. R. at 6. A new psychologist prescribed the same medications Olivia had before, plus a third medication for ADHD. *Id.* During visitation, David again noticed that Olivia seemed lethargic and requested that she be taken off the medication. However, the court found that it fell within "ordinary medical care" under Whittier Juvenile Code §300 and could be administered to Olivia without his consent. *Id.* The court also set the next hearing for three months out, at which time, the decision for Olivia's permanent placement would be made. *Id.* Olivia remained with the same foster family, who wished to adopt Olivia, and continued to lose weight and become more active. *Id.* Her behavioral issues had also improved, so she was only required to take once ADHD medication. *Id.* David, however, missed two of his required parenting classes and continued to bring Olivia junk food from the gas station. *Id.* Olivia also told Sonia that she was happy in her foster home. *Id.* At the permanency hearing three months later, the juvenile court found that it was in Olivia's best interest to grow up in a healthy and permanent home. *Id.* Therefore, pursuant to Whittier Juvenile Code § 200, David's parental rights were terminated. R. at 7.

SUMMARY OF ARGUMENT

The Juvenile Court properly determined by clear and convincing evidence that there was parental misconduct or inability on behalf of the Appellant, pursuant to Whittier Juvenile Code § 200(a), because he contributed to Olivia's obesity and failed to take steps to remedy her serious physical and emotional issues. In addition, the termination of parental rights pursuant to Whittier Juvenile Code § 200(c), was in Olivia's best interests given her physical, mental, and emotional needs for a permanent home. Finally, psychotropic medication fell within the meaning of "ordinary medical care" as described in Whittier Juvenile Code § 300(c)(i), and was properly administered to Olivia at her social worker's consent. For these reasons, Appellee respectfully requests that this court affirm the orders of the Juvenile Court.

STANDARD OF REVIEW

When the burden of proof is clear and convincing evidence, the question that must be answered on appeal is whether the court's findings that the disputed fact was proven by clear and convincing evidence was clearly erroneous. *Jones v. Arkansas Dep't of Human Servs.,* 205 S.W.3d 778, 790 (Ark. 2005). In making a determination of this kind, the case is reviewed *de novo*, but great deference is given to the trial court, given its superior position in determining the credibility of the witnesses placed before it. *Id.* A finding of clearly erroneous is proper when, although there is supporting evidence, the reviewing court taking into consideration the entirety of the evidence, is left with a "definite and firm conviction that a mistake has been made." *Id.* When the outcome of the case rests on statutory construction, the trial court's ruling must be ruled *de novo*. *District of Columbia v. Morrissey*, 668 A.2d 792, 796 (D.C. 1995).

ARGUMENT

I. THE JUVENILE COURT PROPERLY TERMINATED THE APPELLANT'S PARENTAL RIGHTS UNDER WHITTER JUVENILE CODE §200 BECAUSE OLIVIA WAS MORBIDLY OBESE, THE APPELLANT WAS A PRIMARY CAUSE OF HER DEPENDENCY, AND OLIVIA WAS IN NEED OF A PERMANENT HOME.

Childhood obesity is increasing rapidly. With it come serious co-morbid conditions. Varness, et. al, *Childhood Obesity and Medical Neglect*, 123 Pediatrics, 399 (2009). Children who have a body mass index (BMI) in the 99th percentile are considered morbidly obese, which can result in a variety of life threatening diseases and increased mortality rates. Ludwig & Murtagh, *State Intervention in Life-Threatening Childhood Obesity*, 306 J. AM. MED. ASSOC., at 206. Although this is a case of first impression in this court, other jurisdictions have found that a parent allowing their child to become morbidly obese may lead to neglect proceedings. *Brittany T.*, 48 A.D.3d 995 (N.Y. App. Div. 2008); *In the Interest of L.T.*, 494 N.W.2d 450 (Iowa Ct. App. 1992). Child neglect is typically defined as "the failure of caregivers to seek or to provide necessary medical care, which then places the child at serious risk of harm." Varness, *supra* at 400.

In cases involving the termination of parental rights a heavy burden is placed on the party seeking the termination due to the extreme nature of the remedy and its tension with the natural rights of parents. *Jones*, 205 S.W.3d at 789; *In re Sego*, 82 Wash.2d 736, 738 (Wash. 1973). However, courts have held that parental rights will not be enforced to the detriment of the health and well-being of the child, and the rights of parents must give way to the interests and welfare of the child when the natural parents fail to provide reasonable care for their children. *Jones*, 205 S.W. 3d at 790; *In re Sego*, 82 Wash.2d at 738.

According to the Whittier Juvenile Code, in order for the termination of parental rights to be proper several requirements must be met. First, the court must find by present clear and

convincing evidence that there is parental misconduct or inability. WHIT. JUVENILE CODE § 200(a). Once it has been found that parental misconduct or inability exists, the court must then determine that the termination of parental rights is in the best interest of the child. WHIT. JUVENILE CODE § 200(c). Ultimately, termination of the Appellant's parental rights was proper because Olivia's obesity and co-morbid conditions coupled with Appellant's lack of compliance with weight loss goals set by the state and physicians display obvious parental misconduct or inability. Given Olivia's progress outside of her father's care and her need for a stable home, termination of parental rights was the proper course of action. R. at 2-7.

A. Under Whittier Juvenile Code §200(a), There Is Present Clear And Convincing Evidence Of Parental Misconduct Or Inability.

In order to satisfy § 200(a) of the Whittier Juvenile Code, the court must determine that there is present clear and convincing evidence of parental misconduct or inability. WHIT. JUVENILE CODE § 200(a). In order to prove parental misconduct or inability, the court must find that 1) the child is a dependent of the court, as defined in § 100(b) of this code, 2) the lack of proper parental care or control is the cause of the child's status as dependent, 3) such cause of dependency is likely to continue or will not likely be remedied, and 4) the continued cause of dependency is likely to cause serious physical, mental, emotional, or moral harm to the child. *Id.*

1. *Under Whittier Juvenile Code § 100(b), Olivia is a dependent of the court.*

Under § 100(b) of the Whittier Juvenile Code, a child shall be adjudged a dependent of the court if the child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness as a result of the willful or negligent failure of the parent or guardian to provide the child with adequate and appropriate food or medical treatment. WHIT. JUVENILE CODE §100(b). In any custody proceeding, the court must take into account the competing interests involved: that of the parent to maintain family integrity, and that of the state to protect

the interest of the minor child. *In re Juvenile Appeal,* 455 A.2d 1313, 1319 (Conn. 1983). So long as a parent adequately cares for their child, there is usually no reason for the state to step into the private realm of family life, leaving parents to make the best decisions for the raising of their children. *Troxel v. Granville*, 530 U.S. 57, 69 (2000). However at the point where the two interests no longer coincide - where physical injury or harm is found or imminent danger to the child is present, the right of the parent is diminished, making state intervention necessary to protect the child. *In re Juvenile Appeal,* 455 A.2d at 1319-20. The level of risk necessary to deem a child a dependent differs between jurisdiction and cases. However, parents have a legal duty to provide their children with proper medical care, and courts have gone to great lengths to ensure positive outcomes for children. *Iowa v. Karwath,* 199 N.W.2d 147, 150 (Iowa 1972); *In re Julie Anne*, 780 N.E.2d 635 (Ohio Ct. of Common Pleas 2002). According to the American Academy of Pediatrics (AAP), a high likelihood of serious imminent harm is not proven by the mere presence of childhood obesity. Todd Varness, et. al, *Childhood Obesity and Medical* Neglect, 123 PEDIATRICS, 399, 401 (2009). However, where a child's obesity creates a high risk of serious harm that can only be remedied with weight loss, especially where the child has conditions that lead to harm that cannot be reversed when the child becomes an adult, there is a much stronger argument for removal from the home. *Id.*

The level of risk necessary to deem a child a dependent of the state is met where parents neglect their child by failing to take the proper steps to address the fact that their child is obese and is suffering from numerous current and potentially long term health problems as a result. *Brittany T.,* 48 A.D.3d at 996. In *Brittany T,* the child's weight placed her at a 99th percentile BMI which led to a variety of health issues including gallstones, a fatty liver, high blood pressure and cholesterol problems, insulin resistance, joint pain, and psychosocial complications

associated with obesity. *Id.* *C.f. In re Juvenile Appeal*, 455 A.2d at 1321 (holding that in the absence of an immediate risk of harm, it was an error to remove the child from the home). In *Brittany T,* the court held that the respondents neglected their child by failing to take steps to address her obesity, and after failing to abide by court-ordered terms and conditions, removal to a foster care program was proper. *Brittany T.*, 48 A.D. 3d at 996. *See Also In the Interest of L.T.*, 494 N.W.2d at 451-2 (holding that removing a child from the home was proper where the child's obesity was potentially life threatening and already interfered with her participation in the socialization a child requires to develop physically, mentally, and emotionally).

Similar to *Brittany T.* and *In the Interest of L.T.*, where serious imminent and long term health risks existed, in this case, not only was Olivia morbidly obese but she also had numerous current and future health risks and co-morbidities. R. at 2. In *Brittany T.*, the child suffered from many negative side effects of obesity, similar to Olivia, who was diagnosed with hyperlipidemia, fatty liver disease, and impaired fasting glucose, in addition to joint pain. R. at 2. Olivia was also deemed to be at a very high risk for two life threatening diseases - type-2 diabetes and cardiovascular disease - similar to that of the child in *In the Interest of L.T.* *Id.* At the time Olivia was determined a dependent of the court, she not only suffered from two conditions that could only be remedied through medical assistance in conjunction with a lifestyle change but also faced potentially fatal health concerns. *Id.* As in *Brittany T.*, where the parent failed to take proper steps to combat the child's obesity, in this case, although given advice from the doctor and the state, the Appellant consistently failed to take the appropriate steps to combat Olivia's obesity. R. at 3,5. This is displayed by the Appellant's failure to maintain a proper diet for Olivia, attend medical appointments, and engage her in physical activity, dismissing Olivia's morbid obesity as a phase she would grow out of. R. at 2-4.

The Appellant's continued failure to adequately provide the proper foods and nutrition for Olivia, along with Olivia's classification as morbidly obese, in addition to the present and long term health risks facing Olivia, all lead to the conclusion that the court properly deemed Olivia a dependent under § 100(b) of the Whittier Juvenile Code, thereby satisfying §200(a)(i).

2. The lack of proper parental care or control by the Appellant is the cause of the child's dependent status under Whittier Juvenile Code § 200(b)(v).

According to Whittier Juvenile Code § 200(a)(ii), the court must also find that the lack of proper parental care or control by the parent in question is the cause of the child's status as dependent. WHIT. JUVENILE CODE § 200(a)(ii). In order to determine whether the child is without proper parental care and control while in the custody of the parent, the court shall consider, without being limited to, the six factors laid out in § 200(b) of the code. WHIT. JUVENILE CODE § 200(b). For the purposes of this case, § 200(b)(v) of the code is most pertinent, stating that the court shall consider the physical, mental, or emotional neglect of the child or evidence of past physical, mental, or emotional neglect. WHIT. JUVENILE CODE § 200(b)(v). When the child is not within the parent's custody, a child is without proper parental care and control where the parent has failed to develop and maintain a parental bond with the child, to provide for the care and support of the child, or to comply with court ordered reunification plans. WHIT. JUVENILE CODE § 200(d).

A parent is the cause of their child's dependent status where the child, under the parent's care, has failed to lose weight, attend dietary classes, and obtain the care necessary to remedy the obesity, especially when the parent encourages the eating habits. *In the Interest of L.T.*, 494 N.W.2d at 452-3. *C.f. Brittany T.*, 48 A.D.3d at 1000 (stating that although the child gained weight, it cannot be said that the parents had a deliberate and willful disregard for their obligations, because the child had an eating disorder and was consuming inappropriate foods at

school). In *In the Interest of L.T.*, the child was obese and had gained eighty pounds over the last two years under her parent's supervision. *In the Interest of L.T.,* 494 N.W.2d at 451. The child's mother had continuously failed to effectively combat the child's obesity problem and had encouraged the child's eating habits in order to help her deal with the stress of her parents' divorce. *Id.* at 452. *See Also In re G.T.,* 845 A.2d 870, 873 (Pa. 2004) (noting that the parents' conscious decision to forgo medical care for their children was poor judgment and put both children at risk). The court held that, although the parent had taken the daughter to numerous appointments and dieticians, she refused to cooperate in providing the care the child ultimately needed to remedy the obesity, and was a therefore a direct contributor to the child's obesity. *In the Interest of L.T.,* 494 N.W.2d at 453.

Unlike in Brittany *T.*, and even more so than in *In the Interest of L.T.,* Appellant was the direct and prominent cause of Olivia's struggles with obesity. R. at 2-6. Unlike in *Brittany T.*, where the parents took steps to feed their child properly at home, the Appellant did not implement a healthy eating plan for Olivia at home, contributing to her obesity in a larger degree than her improper eating at school. R. at 2-3. For example, the Appellant provided Olivia with McDonald's, donuts, ice cream, and other high-fat foods, both before and after advised not to do so. R. at 2, 5. Also, while Olivia was not in the Appellant's custody, although he attended all sessions and was punctual, he brought Olivia sugary foods during their visits in direct contradiction to the state ordered plans for reunification. R. at 6. If the Appellant did not attempt to provide the proper diet for Olivia during his intermittent visits, it is even more likely that he will not do so if Olivia were in his custody. In addition, similar *In re G.T.*, the Appellant willfully failed to attend required medical examinations or comply with the assistance rendered by the Department of Child Welfare to help implement healthy eating and exercise habits to

combat Olivia's obesity. R. at 2, 3. In *In the Interest of L.T.*, the child, as a result of her parent's neglect, became psychologically disturbed by the stress created by her parents divorce. Similarly, as a result of the obesity caused by the Appellant's failure to tame Olivia's weight gain, Olivia was subjected to name calling and was not happy at school anymore, causing her emotional pain which left her crying in the school restrooms. R. at 3.

Appellant's actions, coupled with the failure to cooperate fully and make positive changes in Olivia's health, display the significant impact the Appellant had on Olivia's obesity, which resulted in her physical, emotional, and mental neglect. It was therefore proper for the juvenile court to find the lack of parental care or control by the Appellant was the cause of Olivia's status as a dependent under Whittier Juvenile Code § 200(b) and § 200(d) and therefore satisfies, by clear and convincing evidence, § 200(a)(ii).

3. *The Appellant's cause of dependency on Olivia is likely to continue if Olivia is not removed from the home*.

Under Whittier Juvenile Code § 200(a)(iii) it must be shown that the cause of dependency, Olivia's obesity in this case, is likely to continue or will not likely be remedied. WHIT. JUVENILE CODE § 200(a)(iii). There is no obligation for the juvenile court to return a child to a parent and wait for an actual harm to take place before terminating parental rights. *In re B.S.*, 618 S.E.2d 695, 699 (Ga. Ct. App. 2005). When a parent has manifested incapacity or indifference to remedy the issues facing their child, despite the offer of appropriate family services, and it is demonstrated that the return of the child to the parent's custody is contrary to the health, safety, or welfare of the child, the court has prolonged removal and even terminated parental rights. *Jones*, 205 S.W. 3d at 790. Even where a parent begins to make improvement as termination of parental rights becomes an imminent possibility, courts will not use this change to outweigh evidence demonstrating a prolonged failure to comply and remedy the situation which

caused the removal in the first place. *Id.* at 791. According to the AAP, in order to allow a child to be removed from the home, effective interventions must exist that will likely have a positive effect for the child. Varness, *supra* at 402-3. Furthermore, for children who are obese and have co-morbid conditions that constitute serious imminent harm, charges of medical neglect may be warranted if all in-home approaches have been exhausted. *Id.* at 403.

In this case, the history and pattern of the Appellant's actions in parenting Olivia display clearly that the cause of dependency will not be remedied if Olivia is returned home. The Appellant was initially told by physicians that Olivia's obesity warranted intervention due to the many risks she faced, yet the Appellant turned down suggestions on how to remedy her obesity and continued to bring home fatty foods. R. at 1-2. Later, the Appellant was told that intervention by the child welfare system might result if no changes were made; however, this was not enough motivation for the Appellant. He still failed to combat the obesity plaguing Olivia. R. at 3-4. After trying the diet for a week and allowing Olivia to participate in a few physical activities, the Appellant gave up on the activities and later willfully failed to attend doctor's appointments. R. at 3. *See In Interest of L.T.,* 494 N.W.2d at 452-3 (finding that where a child under her mother's care failed to lose weight and attend dietary classes, and the mother contributed to the child's unhealthy eating, continued removal and possible termination of parental rights is proper). Not only did the Appellant fail to comply with the doctor's orders initially, when state intervention was only threatened, he later failed to comply after state intervention had taken place. R. at 3, 5. After the state intervened, Olivia was taken from the Appellant. Although he complied with the reunification programs, after Olivia was returned home, her weight gain continued as it had before her removal. R. at 5. *See In re B.S,* 618 S.E.2d at 699 (holding that where a mother did not complete a reunification plan by failing to obtain

stable housing, improve parental skills, or properly care for her child, it was proper to find continued harm would occur if the child was returned home). *C.f. Brittany T.*, 48 A.D.3d at 998-9 (noting that where parents of an obese child follow state orders with a good faith effort, although not perfectly, there is no evidence of a continuous and willful failure to comply with the terms of the state order). The Appellant only began to comply when Olivia was removed from the household, which can arguably be attributed with the fact that the Appellant just wanted to regain custody of Olivia. This argument is supported by the fact that immediately upon Olivia's return to the Appellant's custody he resumed the habits that caused Olivia to become morbidly obese in the first place. R. at 5.

Given the prolonged failure of the Appellant to care for his child properly, even after doctor's warnings and removal of Olivia from the home, it is clear that the cause of dependency will continue and will not be remedied, thereby satisfying Whittier Juvenile Code § 200(a)(iii) by clear and convincing evidence.

4. *The continued cause of dependency will likely cause Olivia to suffer serious physical, mental, or emotional harm.*

In order to satisfy § 200(a)(iv) of the Whittier Juvenile Code, it must be shown by clear and convincing evidence that the continued cause of dependency is likely to cause serious physical, mental, or emotional harm to the child. WHIT. JUVENILE CODE § 200(a)(iv). A child's welfare is the court's primary consideration, and the welfare of the child must prevail over the interest of the parents. *In re Sego*, 82.Wash.2d at 738. According to the AAP, where the parent has been given a "wake up call" as a result of the co-morbidities of their child and still fails to make changes, alternative choices for the child are limited, and removal from the home becomes necessary. Varness, *supra* at 403.

As dictated above, Olivia faces numerous current and future health risks in addition to her already prevalent co-morbidities. R. at 2. Therefore, it is clear that serious life-threatening physical harm will occur if her obesity is not confronted head-on. However, in addition to the obvious physical harm that will result if Olivia's obesity is not tamed, serious emotional harm is a side effect of obesity. As the record states, the Appellant's neglect subjected Olivia to bullying for her obesity, which not only forced her to the bathroom for reprieve, but also caused her to miss school on occasion. R. at 3-4. *See In Interest of L.T.*, 494 N.W.2d at 451 (noting that a child's morbid obesity already interfered with her participation in the socialization a child requires to develop physically, mentally, and emotionally). If Olivia's emotional problems persist, she will not be able to enjoy the fundamental right of a nourishing and social childhood, which will likely have a serious long term effect on her ability to interact normally among the population.

In addition to the current, and potentially life-threatening physical health conditions that face Olivia, she is also confronted with emotional problems that could have a detrimental impact on her life both currently and in the future, thereby establishing § 200(a)(iv) of the Whittier Juvenile Code, that Olivia's obesity and the Appellant's medical neglect is likely to cause serious physical, mental, or emotional harm.

B. Under Whitter Juvenile Code § 200(c), Termination Of Parental Rights Is In Olivia's Best Interest, Given Her Physical, Emotional, Mental, And Moral Needs.

Under Whittier Juvenile Code § 200(c), once clear and convincing evidence has proven parental misconduct or inability, the court must determine if termination of parental rights is in the best interest of the child. WHIT. JUVENILE CODE § 200(c). When the state seeks to terminate parental rights, they are not only trying to infringe upon a fundamental right, but they seek to end it. *Santosky v. Kramer*, 455 U.S. 745, 759 (1982). It is for this reason that in parental right

termination proceedings, there is a heavy burden placed on the party seeking to terminate the relationship. *Jones,* 205 S.W.3d at 780. Therefore, such parental rights shall only be abridged when demanded given the facts and circumstances on an ad hoc basis. *In re Sego,* 82.Wash.2d at 738. However, it is well established that children need a permanent home in order to provide emotional stability. *In re B.S.*, 618 S.E.2d at 700. Given the well known deleterious effects of prolonged temporary placement on a child, it is imperative that action is taken to either reunite the families or terminate parental rights in order to free neglected children for placement in stable family homes. *In re Juvenile Appeal,* 455 A.2d at 1322.

Termination of parental rights is proper where a child has made tremendous nutritional and developmental gains since being in foster care, the natural parent shows no indication that they are prepared to care for the child, and prolonged foster care will have a detrimental effect on the child. *In re B.S.*, 618 S.E.2d at 696. In *In re B.S.*, a child was removed from the home at three months of age due to malnourishment and lack of medical attention from the parent. *Id.* at 696-7. Once in foster care, the parent still failed to completely follow the requirements laid out by the state. *Id.* at 697. On the other hand, the child's health improved dramatically after being removed from the mother's care. *Id.* at 698. After finding parental misconduct or inability, the court terminated parental rights to the child. *Id.* at 698-700. *See also Jones*, 205 S.W.3d at 791-2 (holding that termination of parental rights was in the best interest of the child where the parents made some effort to follow court orders, but the return to a family home could not be accomplished in a reasonable amount of time). The court held that given the adverse affects of prolonged foster care, the gains the child has made since out of the parents custody, and the indication that the parent is unprepared to care for the child, termination of parental rights was proper. *In re B.S.*, 618 S.E.2d at 700.

Even more so than in both *Jones* and *In re B.S.*, where parental rights were terminated when the parents did not properly follow state instructions, the children excelled while out of the parent's control, and the parents were not ready to care for the children in the immediate future, Olivia's case warrants termination of parental rights. The Appellant failed to follow state instructions, knowing that parental termination was the ultimatum if he did not cooperate, displaying that he truly was not willing or capable of properly caring for Olivia. R. at 3, 5. Even more convincing than that of the child in *In re B.S.*, Olivia made drastic improvements while out of the Appellant's care, losing weight on a daily basis, and feeling more comfortable with herself. R. at 4, 6-7. Olivia was happy to go to school, and enjoyed the way she looked and the stability that she encountered with her foster family. R. at 6. Although the Appellant may argue that Olivia was still emotionally unstable while in foster care, Olivia's emotional instability was only caused by her lack of a permanent home, which is an influential reason for the termination of parental rights. R. at 4. The Appellant may be able to change his parental abilities in the future, similar to that seen in *In re B.S.*, however, it would be unfair to Olivia to be denied permanency of residence, after having already been removed from the home, returned, and removed again. R. at 3, 5-6. Due to the detrimental effects the lack of a permanent home could have on Olivia, and the Appellant's failure to take the appropriate steps for Olivia to return home, terminating parental rights and allowing the Fishers to adopt Olivia is the most desirable course of action.

Under Whittier Juvenile Code § 200(c), termination of parental rights is the proper course of action in order to ensure that Olivia has a secure and stable home.

II. PSYCHOTROPIC MEDICATION WAS WITHIN THE MEANING OF "ORDINARY MEDICAL CARE" AS DESCRIBED IN WHITTIER JUVENILE CODE § 300(c)(i).

Under the Whittier Juvenile Code, a child in the legal custody of the state may receive ordinary medical care, including mental health care, with the exception of inpatient psychiatric treatment at the consent of their social worker. WHIT. JUVENILE CODE § 300. The administration of psychotropic medication to Olivia Smith, a child in foster care, at the consent of her social worker, did constitute ordinary medical care under the Whittier Juvenile Code because the language of the statute is clear, it is reasonable to interpret psychotropic medication as part of ordinary medical care, and it is good policy to allow legal guardians to consent to treatment with psychotropic medications.

A. The Administration Of Psychotropic Medication Is Clearly Allowed Within The Language Of The Statute.

Administering psychotropic medication to Olivia Smith at the consent of her social worker was clearly allowed by Whittier Juvenile Code §300 (a)-(c)(i), which state that children in foster care may receive ordinary medical care at the discretion of the child's social worker. *Id.* Within the definition of ordinary medical care is "mental health treatment other than inpatient psychiatric hospitalization." WHIT. JUVENILE CODE § 300(c)(i). The only exception to mental health treatment that the statute carves out is inpatient psychiatric hospitalization. Had Whittier state legislators intended to exclude psychotropic medication from the scope of ordinary medical care, they would have drafted the statute differently. There are several states which specifically exclude psychotropic medication from the scope of ordinary medical care, and the language of their statutes or their case law is unambiguous in making this distinction. *See e.g.* CAL. WELF. & INST. CODE § 739.5(a) (West 2011); FLA. STAT. § 39.407(3) (2011). Furthermore, there are states that allow psychotropic medication to be administered absent parental consent, so it is not unreasonable to interpret Whittier's statute to include psychotropic medication within the scope of ordinary medical care. *See e.g.* TENN. DEP'T OF CHILDREN'S SERVS ADMINISTRATIVE

POLICIES AND PROCEDURES 20.24; OR. ADMIN. R. 413-070-0470 through 0490 (West 2011); OKLA. ADMIN. CODE 340:75-6-88 (b)(2011); Authority to Consent to Medical and Mental Health Treatment, Del. Op. Att'y. Gen. 95-IB18, (1995).

States in which psychotropic medication is not considered part of ordinary medical care have statutes that are unambiguous in regard to the matter. California's statute states "only a judicial officer shall have authority to make orders regarding the administration of psychotropic medications…." CAL. WELF. & INST. CODE §739.5(a) (West 2011). The statute requires a court order, but not parental consent to psychotropic medication. In some cases, the court may delegate the power to make the decision to the parent of the child, but the "default" authority for the decision is the court. *Id.* Key to note is that the statute is impeccably clear in delegating the decision-making authority over the administration of psychotropic medication. The state of Florida has taken an approach different from that of California. Florida's statute states that "before the department provides psychotropic medication to a child in its custody, the prescribing physician shall attempt to obtain express and informed consent … from the child's parent or legal guardian." FLA. STAT. § 39.407(3)(a)1(2011). Under the statute, when parental consent for the administration the medication cannot be obtained (due to the parent's unavailability or refusal to consent) a court order must be obtained. *Id.* However, if delays in administering the medication will likely result in significant harm to the child, the medication may be administered prior to obtaining a court order. FLA. STAT. § 39.407(3)(e)(2011).

First, even if Whittier state legislators intended for psychotropic medication to be treated differently from other medical care and took an approach similar to that of the state of Florida, Olivia may have legally been administered psychotropic medication absent her father's consent due to the severity of her behavior. Her mental health issues caused her to throw objects at her

foster mother, punch another child at summer camp, and bang her head on the floor. R. at 4. Certainly, Olivia's behavior is that which the Florida statute describes as a cause of "significant harm" and would warrant administration of the medication prior to obtaining a court order. FLA. STAT. § 39.407 (3)(e) (2011). However, Whittier's statute does not prescribe a special consent process for the administration of psychotropic medication, as seen in the California and Florida statutes, therefore it is logical to conclude that legislators intended that psychotropic medication be part of "ordinary medical care."

In contrast to Florida and California, some states, like the state of Whittier, have explicitly or implicitly included psychotropic medication as part of ordinary medical care. *See e.g.* TENN. DEP'T OF CHILDREN'S SERVS ADMINISTRATIVE POLICIES AND PROCEDURES 20.24; OR. ADMIN. R. 413-070-0470 through 0490 (West 2011); OKLA. ADMIN. CODE 340:75-6-88(b)(2011). Tennessee has done so by allowing a Department of Child Services nurse to approve a prescription for psychotropic medication in the case that a parent is not present at the appointment where the medication is prescribed and cannot be reached by phone. TENN. DEP'T OF CHILDREN'S SERVS ADMINISTRATIVE POLICIES AND PROCEDURES 20.24(H)(3) (2011). A court order is only required if the natural parent objects to the prescription of psychotropic medication. TENN. DEP'T OF CHILDREN'S SERVS. ADMINISTRATIVE POLICIES AND PROCEDURES 20.24(H)(7) and (K)(5) (2011). Oregon's pertinent rule is one of the more permissive rules among the states because it allows a Child Welfare Program Manager to consent to the administration of psychotropic medication if the Department of Child Services is the legal guardian of the child. OR. ADMIN. R. 413-070-0470 through 0490 (West 2011). Oklahoma specifically enumerates psychotropic medication as part of routine and ordinary medical care. OKLA. ADMIN. CODE 340:75-6-88(b)(3)(K)(2011). The policy, like the policy in the state of Tennessee, requires that

the parent be notified of the provision of the medication and that the parent still be "involved" in the care, but, unlike other states, does not require a court order. OKLA. ADMIN. CODE 340:75-6-88(b)(4)(A)(2011). The state of Delaware's statute reads almost identically to Whittier's, stating that ordinary medical care means "medical examination [and] medical treatment including surgical procedures and mental health treatment other than inpatient psychiatric hospitalization." DEL. CODE. ANN. TIT. 31 § 5101 (West 2011). The Delaware Attorney General issued an opinion which directly addressed the administration of psychotropic medication to minors under the care of the Division of Family Services. The opinion stated that

> "While the use of psychotropic medications would not be considered routine treatment, … the use of such medications would be deemed to be necessary, proper and expedient in providing the out-patient treatment. Thus, in those instances in which parents were unavailable to consent to the use of psychotropic medications, [the state] agency would be statutorily authorized to make use of them…."
> Authority to Consent to Medical and Mental Health Treatment, Del. Op. Att'y. Gen. 95-IB18, (1995).

In short, although not "routine" the administration of psychotropic medication is still "ordinary" under the Delaware statute, and the state agency may consent if the parent is unavailable. As in Tennessee and Oklahoma, if the parent objects to the medication, then a court order must be obtained. Authority to Consent to Medical and Mental Health Treatment, Del. Op. Att'y. Gen. 95-IB18, (1995); *see e.g.* TENN. DEP'T OF CHILDREN'S SERVS. ADMINISTRATIVE POLICIES AND PROCEDURES 20.24; OKLA. ADMIN. CODE 340:75-6-88(b)(2011). While Delaware's statute applies to minors who are wards of the state due to delinquency, it makes even more sense to delegate decision making authority to the Child Welfare Agency in cases of child neglect. DEL. CODE ANN. TIT. 31 § 5102 (West 2011).

Considering the official policies in Oregon, Tennessee, Oklahoma, and Delaware, it is more than reasonable to interpret Whittier's statute to include psychotropic medication within the

definition of ordinary medical care and allow its administration absent parental consent. The similarities between Delaware's statute and the related Attorney General opinion make the case for considering psychotropic medication as part of ordinary medical care especially persuasive. DEL. CODE ANN. TIT. 31 § 5102 (West 2011); Authority to Consent to Medical and Mental Health Treatment, Del. Op. Att'y. Gen. 95-IB18, (1995). Given the severity of Olivia's behavioral issues, the psychotropic medications would certainly fall within the ambit of what the Delaware Attorney General terms "necessary, proper, and expedient in providing out-patient treatment." Authority to Consent to Medical and Mental Health Treatment, Del. Op. Att'y. Gen. 95-IB18, (1995). Furthermore, David was deemed to be unfit to care for Olivia and she had been removed from his care, and, as the Whittier State Court of Appeals noted, it is arguable that he was essentially unavailable. R. at 12.

B. It Is Good Public Policy To Leave The Decision Of Whether To Administer Psychotropic Medication To Foster Children In The Hands Of Their Social Workers.

Although the statutory language is clear, public policy considerations may be helpful in interpreting the statutes. *M.W. Erectors, Inc. v. Niederhauser Ornamental and Metal Works Co., Inc.*, 36 Cal. 4th 412, 426 (Cal. 2005). Good public policy dictates that decisions pertaining to a child's well-being be delegated to either a foster parent or a social worker. Foster children represent a portion of the population who are most in need of psychotropic medications. Furthermore, especially in cases like Olivia's where the child is in the legal custody of the state due to medical neglect, it is fit to delegate authority over medical decisions to the current legal custodian. Lastly, requiring a court order for the administration of psychotropic medication promotes judicial inefficiency and unwise expenditure of precious resources.

Firstly, foster children are especially vulnerable to mental health issues. The AAP acknowledged that children in foster care, on average, have more psychiatric problems than their

peers. Julie M. Zito, et. al, *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 PEDIATRICS 157, 162 (2008). A 1998 California study of 267 children in foster care in three counties observed that the children had two and a half times the normal rate expected in a community sample. June M. Clausen, et. al, *Mental Health Problems of Children in Foster Care*, 7 J. CHILD & FAM. STUD. 283, 283 (1998). Connecticut's Department of Children and Families advisory committee, points to studies that show that approximately seventy-eight percent of foster children suffer from some kind of serious emotional disturbance and anywhere from thirty-nine to eighty percent are in need of mental health treatment. DEP'T OF CHILDREN & FAMILIES, GUIDELINES FOR PSYCHOTROPIC MEDICATION USE IN CHILDREN AND ADOLESCENTS (2010). The Texas Department of Family and Protective services points out that most foster children have suffered some kind of traumatic experience that would warrant the administration of psychotropic medication, whether that experience be the situation that warranted their removal from their homes or the impact of having to adjust to a new home environment. TEX. DEP'T OF FAM. AND PROTECTIVE SERV., PSYCHOTROPIC MEDICATION UTILIZATION PARAMETERS FOR FOSTER CHILDREN (2010). Certainly, Olivia is no exception to these statistics. Prior to removal from her father's care, she was already suffering emotional issues precipitating from her obesity and the treatment she received at school. R. at 3, 4. Removal from her father and grandmother's care only compounded the emotional stressors placed on her, and her extreme behavior in foster care demonstrated her need for psychotropic medication to address these issues. R. at 4.

Second, placing medical decisions (including the administration of psychotropic medication) back into the hands of those parents who have been deemed to be abusing or neglecting their children cannot be in the child's best interest. Parental rights to decision-making for children are not absolute, and there have been several cases in which overriding a parent's

decision-making rights was deemed to be within a child's best interest. *Ginsberg v. New York*, 390 U.S. 629, 640 (1968); *Prince v. Massachusetts*, 321 U.S. 158, 165, (1944). For example, the court overruled a parent's right to compel her child to pass out leaflets as part of a religious practice because it violated child labor laws. *Prince,* 321 U.S. at 165. It was also ruled appropriate to intervene when children were being exposed to pornographic material by their parent. *Ginsberg*, 390 U.S. at 640. The United States Supreme Court ruled that a Georgia State procedure which allowed a custodial agency to act *in loco parentis* when deciding whether or not to commit a child to a mental hospital was constitutional. *Parham v. J. R.,* 442 U.S. 584 (1979). If overriding a parent's right in the area of free exercise of religion, as in *Prince*, was deemed to be permissible, certainly overriding a parent's right in the area of consent for medical treatment is more than appropriate. Furthermore, if a state procedure allowing the state to decide whether or not to commit a child to a residential facility was ruled constitutional, it is not unreasonable to say that a state may decide whether to administer psychotropic medication to a child who is in the state's legal custody. Lastly, Olivia was placed in foster care due to medical neglect, so it would be unwise to leave the decision of whether or not to provide her with psychotropic medication – a medical decision – in the hands of the person who was medically neglecting her.

Finally, polices that require a court order prior to the administration of psychotropic medication greatly reduce judicial efficiency given the number of foster children who require psychotropic medications. Provided that proper safeguards are implemented to ensure that children are not being prescribed harmful medications, the decision can be appropriately made by a social worker. If Whittier's statute were interpreted to require a court order for the administration of psychotropic medication to a foster child, each decision in which parental consent cannot be obtained would have to go through the court system, consuming valuable time

and resources. The decision would better be made by the child's foster parent, social worker, or treating medical professional, as these individuals have more regular, personal contact with the children that they oversee, and are therefore best equipped to make the decision. Furthermore, a foster parent, social worker, or treating nurse would be more readily accessible and would be able to get children the medication that they need more rapidly, while waiting on a court order could take a significant amount of time. In Olivia's case, the psychiatrist took proper precautions prior to prescribing Olivia's medications by performing the necessary tests. R. at 5. Sonia, having been Olivia's social worker for some time, was familiar with Olivia's behavioral issues and was adequately prepared to give consent for the medication, making her consent, rather than a court order, in Olivia's best interest.

Based on the clear language of the statute and good public policy, the administration of psychotropic medication to children in the legal custody of the state is part of "ordinary medical care" as described in Whittier Juvenile Code §300.

CONCLUSION

The Appellee thereby respectfully requests that this Court affirm the orders of the Juvenile Court.

Dated: January 7, 2011

Respectfully Submitted,

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Team 104

Counsel for Appellee

APPENDIX

STATE OF WHITTIER – JUVENILE CODE

Whittier Juvenile Code § 100 - Conditions of Abuse or Neglect

Any child who comes within any of the following descriptions is within the jurisdiction of the juvenile court which may adjudge that person to be a dependent child of the court:

(a) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted non-accidentally upon the child by the child's parent or guardian. For the purposes of this subdivision, a court may find there is a substantial risk of serious future injury based on the manner in which a less serious injury was inflicted, a history of repeated inflictions of injuries on the child or the child's siblings, or a combination of these and other actions by the parent or guardian which indicate the child is at risk of serious physical harm. For purposes of this subdivision, "serious physical harm" does not include reasonable and age-appropriate spanking to the buttocks where there is no evidence of serious physical injury.

(b) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure or inability of his or her parent or guardian to adequately supervise or protect the child, or the willful or negligent failure of the child's parent or guardian to adequately supervise or protect the child from the conduct of the custodian with whom the child has been left, or by the willful or negligent failure of the parent or guardian to provide the child with adequate and appropriate food, clothing, shelter, or medical treatment, or by the inability of the parent or guardian to provide regular care for the child due to the parent's or guardian's mental illness, developmental disability, or substance abuse.

(c) The child is suffering serious emotional damage, or is at substantial risk of suffering serious emotional damage, evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, as a result of the conduct of the parent or guardian or who has no parent or guardian capable of providing appropriate care. No child shall be found to be a person described by this subdivision if the willful failure of the parent or guardian to provide adequate mental health treatment is based on a sincerely held religious belief and if a less intrusive judicial intervention is available.

(d) The child has been sexually abused, or there is a substantial risk that the child will be sexually abused, by his or her parent or guardian or a member of his or her household, or the parent or guardian has failed to adequately protect the child from sexual abuse when the parent or guardian knew or reasonably should have known that the child was in danger of sexual abuse.

(e) The child is under the age of five years and has suffered severe physical abuse by a parent, or by any person known by the parent, if the parent knew or reasonably should have known that the person was physically abusing the child. For the purposes of this subdivision, "severe physical abuse" means any of the following: any single act of abuse which causes physical trauma of sufficient severity that, if left untreated, would cause permanent physical disfigurement, permanent physical disability, or death; any single act of sexual abuse which causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal

swelling, bone fracture, or unconsciousness; or the willful, prolonged failure to provide adequate food. A child may not be removed from the physical custody of his or her parent or guardian on the basis of a finding of severe physical abuse unless the social worker has made an allegation of severe physical abuse.

(f) The child's parent or guardian caused the death of another child through abuse or neglect.

(g) The child has been left without any provision for support; physical custody of the child has been voluntarily surrendered and the child has not been reclaimed within a 14-day period; the child's parent has been incarcerated or institutionalized and cannot arrange for the care of the child; or a relative or other adult custodian with whom the child resides or has been left is unwilling or unable to provide care or support for the child, the whereabouts of the parent are unknown, and reasonable efforts to locate the parent have been unsuccessful.

(h) The child has been freed for adoption by one or both parents for 12 months by either relinquishment or termination of parental rights or an adoption petition has not been granted.

(i) The child has been subjected to an act or acts of cruelty by the parent or guardian or a member of his or her household, or the parent or guardian has failed to adequately protect the child from an act or acts of cruelty when the parent or guardian knew or reasonably should have known that the child was in danger of being subjected to an act or acts of cruelty.

(j) The child's sibling has been abused or neglected, as defined in subdivision (a), (b), (d), (e), or (i), and there is a substantial risk that the child will be abused or neglected, as defined in those subdivisions. The court shall consider the circumstances surrounding the abuse or neglect of the sibling, the age and gender of each child, the nature of the abuse or neglect of the sibling, the mental condition of the parent or guardian, and any other factors the court considers probative in determining whether there is a substantial risk to the child.

As used in this section, "guardian" means the legal guardian of the child.

Whittier Juvenile Code § 200 - Termination of Parental Rights

(a) In considering the termination of parental rights, the court shall first determine whether there is present clear and convincing evidence of parental misconduct or inability. The court determines parental misconduct or inability by finding that:

(i) The child is a dependent of the court, as such term is defined in Whittier Juvenile Code § 100;

(ii) The lack of proper parental care or control by the parent in question is the cause of the child's status as dependent;

(iii) Such cause of dependency is likely to continue or will not likely be remedied; and

(iv) The continued cause of dependency is likely to cause serious physical, mental, emotional, or moral harm to the child.

(b) In determining whether the child is without proper parental care and control, the court shall consider, without being limited to, the following:

(i) A medically verifiable deficiency of the parent's physical, mental, or emotional health of such duration or nature as to render the parent unable to provide adequately for the physical, mental, emotional, or moral condition and needs of the child;

(ii) Excessive use of or history of chronic unrehabilitated abuse of intoxicating liquors or narcotic or dangerous drugs or controlled substances with the effect of rendering the parent incapable of providing adequately for the physical, mental, emotional, or moral condition and needs of the child;

(iii) Conviction of the parent of a felony and imprisonment therefore which has a demonstrable negative effect on the quality of the parent-child relationship;

(iv) Egregious conduct or evidence of past egregious conduct of the parent toward the child or toward another child of a physically, emotionally, or sexually cruel or abusive nature;

(v) Physical, mental, or emotional neglect of the child or evidence of past physical, mental, or emotional neglect of the child or of another child by the parent; and

(vi) Injury or death of a sibling under circumstances which constitute substantial evidence that such injury or death resulted from parental neglect or abuse.

(c) If there is clear and convincing evidence of such parental misconduct or inability, the court shall then consider whether termination of parental rights is in the best interest of the child, after considering the physical, mental, emotional, and moral condition and needs of the child who is the subject of the proceeding, including the need for a secure and stable home.

(d) Where the child is not in the custody of the parent who is the subject of the proceedings, in determining whether the child is without proper parental care and control, the court shall consider, without being limited to, whether the parent without justifiable cause has failed significantly for a period of one year or longer prior to the filing of the petition for termination of parental rights:

(i) To develop and maintain a parental bond with the child in a meaningful, supportive manner;

(ii) To provide for the care and support of the child as required by law or judicial decree; and

(iii) To comply with a court ordered plan designed to reunite the child with the parent or parents.

Whittier Juvenile Code § 300 – Custodial Responsibilities

(a) Any child who is adjudged a dependent of the court shall also be in the legal custody of the State.

(b) When a child is in the legal custody of the state, the child's social worker may consent to medical care on behalf of the child which is otherwise permitted under law.

(c) "Legal custody" denotes those rights and responsibilities associated with the day to day care of the children. It includes the right to the care, custody and control of the child. It includes the duty to provide food, clothing, shelter, education, and ordinary medical care, and to train and discipline.

(i) "Ordinary medical care" shall mean medical examination, medical treatment including minor surgical procedures and mental health treatment other than inpatient psychiatric hospitalization.

(ii) All other medical procedures shall require parental consent; where consent cannot be obtained because the parent is unavailable or because parental rights have been terminated, a court order shall be required.