No. 923-2011

IN THE

SUPREME COURT OF THE STATE OF WHITTIER

SPRING TERM 2012

David SMITH,
Plaintiff-Appellant,

v.

Kathryn CANDLER, Director, Whittier Department of Child Welfare,
Defendant-Appellee.

ON WRIT OF CERTIORARI
TO THE STATE OF WHITTIER COURT OF APPEAL

BRIEF FOR APPELLEE

January 6, 2012

Counsel for Appellee

QUESTIONS PRESENTED

I. Did David Smith's willful failure to treat Olivia Smith's morbid obesity and co-morbid conditions justify her removal under Whittier Juvenile Code Section 100, and the termination of David's parental rights for his egregious conduct under Whittier Juvenile Code Section 200?

II. Was the Department's administration of medication to treat Olivia's mental illness ordinary medical care under Whittier Juvenile Code Section 300, which authorizes all mental health treatments except inpatient psychiatric hospitalization?

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OPINIONS BELOW

The unreported opinion of the Whittier Court of Appeal, affirming the orders of the Whittier Juvenile Court, appears on pages 1-12 of the record. *Smith v. Whittier*, __ P.3d __ (Whit. Ct. App. 2011).

JURISDICTIONAL STATEMENT

This Court has jurisdiction to review the Whittier Court of Appeal decision pursuant to Whittier Juvenile Code Section 100. This Court granted certiorari on November 18, 2011.

STATEMENT OF THE CASE

Statement of the Facts

David Smith is a single father and eleven-year-old Olivia Smith's sole parent. (J.A. 1.) Olivia has struggled with her weight for years; since 2005, doctors warned David that Olivia needed to lose weight. (J.A. 1, 2.) The doctors explained that Olivia faced multiple life threatening health conditions due to her weight, but David consistently rejected recommended weight-loss treatments, responding that Olivia was "just fine," and "would grow out of it." (J.A. 2, 3, 6.) Rather than trying to curb Olivia's junk food consumption, David fed her chips, soda, croissants, and cookies from the gas station. (J.A. 2.)

In June 2008, Doctor Masters informed the Smiths that eight-year-old Olivia weighed one hundred pounds, qualifying her as morbidly obese. (J.A. 2.) Olivia also had co-morbidities associated with diabetes, cardiovascular disease, and cirrhosis, and difficulty walking due to weight-strained joints. (J.A. 2.) Dr. Masters reaffirmed what previous doctors had told the Smiths: Olivia's weight and co-morbidities were life threatening but reversible, and weight-loss was essential to her treatment. (J.A. 2.) Dr. Masters warned David that until Olivia lost weight, she risked life threatening type-II diabetes, polycystic ovarian disease, sleep apnea, and cardiovascular disease. (J.A. 2.) Dr. Masters placed Olivia on a low-calorie diet and emphasized that she needed to limit her junk food intake. (J.A. 2.) Dr. Masters told David to enroll Olivia in athletic activities at the YMCA four days a week. (J.A. 2.) She scheduled a six-month check-up and advised David that if Olivia had not lost weight, the Whittier Department of Child Welfare (the "Department") might intervene. (J.A. 2.)

Six months later, Olivia had gained ten pounds. (J.A. 2.) David again excused her weight, giving up on the diet the first week after Olivia snuck food at school. (J.A. 2.) Olivia

said she enjoyed sports classes, but David had trouble transporting her, so he only took her twice a week. (J.A. 2, 3.) Olivia missed attending the classes, so Dr. Masters informed David about a free dance program one mile from his apartment. (J.A. 3.) Dr. Masters also gave David healthy dinner recipes and ordered weekly home visits with a community health nurse. (J.A. 3.) She scheduled a second check-up one month later, emphasizing that Olivia's obesity and co-morbidities were potentially life threatening and reminding David that he risked Department intervention if Olivia did not lose weight. (J.A. 3.)

The Smiths did not return for Olivia's second check-up. (J.A. 3.) Though the community nurse made both scheduled and unannounced visits to the apartment, she never met David or Olivia. (J.A. 3.) David knew Olivia was gaining weight but made no effort to follow Dr. Masters' recommendations. (J.A. 3.) Dr. Masters notified the Department of Olivia's morbid obesity and David's ongoing failure to address it. (J.A. 3.)

The Department responded by sending social worker Sonia White to meet David and Olivia. (J.A. 3.) Olivia told Sonia that kids regularly bullied her, calling her "pig" and "fatso." (J.A. 3.) The school nurse even found her crying in the bathroom one day. (J.A. 3.) Olivia also said she used to get good grades and enjoy going to school, but that now she was failing most classes. (J.A. 3.) At the end of her visit, Sonia informed David of the upcoming Juvenile Court dependency hearing. (J.A. 4.)

At the hearing, the Juvenile Court found that Olivia was neglected under Whittier Juvenile Code Section 100 due to the imminent risk of physical harm her obesity caused. (J.A. 4.) The court placed Olivia with a foster family, Martha and Frank Fisher, who had another foster child, Samantha, and David signed a form authorizing the Department to administer ordinary medical care to Olivia. (J.A. 4.) The court also enrolled him in Family Reunification

Services, including twice-weekly parenting classes, a six-week child nutrition class, and unsupervised visits with Olivia one weekend day every other week. (J.A. 4.)

Olivia was instantly happy with the Fishers. (J.A. 4.) She liked having a mom, got along with Samantha, and enjoyed eating healthy organic foods and attending dance classes. (J.A. 4.) Her weight dropped from 112 pounds to 102 pounds in three months and her nurse practitioner found that her co-morbidities had also improved. (J.A. 4.)

After four months, however, Olivia began exhibiting erratic behavior. (J.A. 4.) Although she used to like summer camp, she had begun banging her head on the floor and throwing food each morning in protest. (J.A. 4.) Martha found Olivia crying in the closet on three separate occasions. (J.A. 4.) Later, Olivia was excused from camp for being disruptive and punching a boy camper who called her "fatso" and insulted her foster status. (J.A. 4.) Sonia advised Martha to take Olivia to see Dr. Wilmington, a child psychiatrist at the health clinic. (J.A. 4.)

Olivia told Dr. Wilmington that she felt sad and angry all the time. (J.A. 4.) He diagnosed Olivia with depression and bipolar disorder, and ordered tests to be completed before psychotropic medications could be prescribed. (J.A. 5.) With Sonia's approval, Olivia began taking Depakote and Lexapro. (J.A. 5.) Once, David complained to Sonia about Olivia's medicine. (J.A. 5.) Sonia replied that he could bring it up at the six-month review, but that the medical waiver he had signed authorized the Department to provide medication. (J.A. 5.)

At the six-month review, Olivia had lost twenty-two pounds; the Juvenile Court returned her to her father's care under continued Department supervision, including weekly visits with a nutritionist and weigh-ins. (J.A. 5.) The court urged David to emulate the Fisher's healthy lifestyle by keeping Olivia involved in activities, and reminded him that her weight must decrease by the twelve-month hearing. (J.A. 5.)

Back in David's care, Olivia stopped taking her medication, and David failed to take her to the nutritionist or weigh-ins. (J.A. 5.) Sonia observed that Olivia had gained weight after becoming sedentary and returning to her junk-food diet. (J.A. 5.) Sonia reiterated Olivia's need to continue losing weight via a healthy diet and exercise in order to remain with David. (J.A. 5.)

By the twelve-month hearing, Olivia had gained five pounds and the Juvenile Court ordered her back into the Fishers' care. (J.A. 6.) With the Fishers, Olivia resumed her active lifestyle. (J.A. 6.) She enjoyed soccer, cheerleading, and gardening. (J.A. 6.) However, she soon experienced behavior problems again. (J.A. 6.) This time, Dr. Kent at the clinic prescribed Lexapro, Depakote, and Adderall to treat Attention Deficit Hyperactivity Disorder. (J.A. 6.)

Six months after returning to the Fishers—at the eighteen-month hearing—Olivia weighed eighty-five pounds. (J.A. 6.) Although David finally challenged Olivia's prescribed medications at the hearing, the court found that the medication was ordinary medical care under Whittier Juvenile Code Section 300(c)(i) and ordered continued Family Reunification Services. (J.A. 6.) The court warned David that it was his last chance to prove himself before Olivia's permanent custody hearing. (J.A. 6.) Prior to the permanency hearing, David missed two parenting classes, and brought Olivia gummy bears on an unsupervised visit, forcing Sonia to remind him yet again not to provide Olivia with sugary foods. (J.A. 6.)

At the permanent custody hearing, Sonia reported Olivia's success with the Fishers, and David's continued lack of appropriate parenting skills. (J.A. 7.) In the Fishers' care, Olivia's weight had dropped to eighty pounds, school kids no longer teased her, and her behavior had improved so significantly that she no longer needed Depakote or Lexapro. (J.A. 6.) The Fishers wanted to adopt Samantha and Olivia, and Olivia testified that she liked her new mommy and daddy, that they knew how to take care of her, and had helped her become healthy so that kids no

longer teased her. (J.A. 6, 7.) The Juvenile Court found that David's parenting skills were inadequate and terminated his parental rights. (J.A. 7.)

Procedural History

On March 2, 2009, the Juvenile Court found that Olivia was a neglected child under Section 100(b). (J.A. 2-4.) The court adjudicated her a juvenile dependent, and ordered Family Reunification Services. (J.A. 4.) David signed a form authorizing the Department to administer "ordinary medical care" to Olivia under Section 300. (J.A. 4.)

In September 2009, the Juvenile Court held a six-month review hearing, where it found that Olivia had lost twenty-two pounds and ordered her return to David's care. (J.A. 5.) The court stipulated that it would return Olivia to Department custody unless her weight had decreased at the March 2010 twelve-month hearing. (J.A. 5.)

At the twelve-month hearing, Olivia's weight had increased. (J.A. 6.) The court ordered Olivia's re-placement with the Fishers. (J.A. 6.)

In September 2010, at the eighteen-month hearing, the court found that Olivia had lost weight in the Fishers' care. (J.A. 6.) David requested that Olivia be taken off any medications she was prescribed while dependent. (J.A. 6.) The court denied his request, finding that the medications were included in "ordinary medical care" under Section 300. (J.A. 6.) The court ordered Olivia to remain in foster care with continued Family Reunification Services. (J.A. 6.)

At the January 2, 2011, permanency hearing, the court terminated David's parental rights pursuant to Section 200, citing Olivia's need to grow up in a permanent, healthy home. (J.A. 7.)

On appeal, David challenges the court's finding of parental neglect due to Olivia's obesity, and its subsequent termination of David's parental rights. (J.A. 1.) David also appeals

the Juvenile Court's finding that the administration of psychotropic medication constitutes ordinary medical care under the terms of Section 300. (J.A. 1.)

SUMMARY OF ARGUMENT

This Court should affirm the decision of the Jenning County Juvenile Court and the Whittier Court of Appeal by holding that Appellant's parental rights were properly terminated due to medical neglect. This Court should also affirm the lower courts' decisions that the Department's administration of medication was ordinary medical care under Whittier Juvenile Code Section 300.

Olivia's untreated morbid obesity and co-morbid conditions caused her serious physical harm, and a substantial risk of further life threatening harm, under Whittier Juvenile Code Section 100. David ignored the severity of Olivia's conditions and flouted admonitions from doctors, the Department, and the Juvenile Court to treat Olivia's obesity. It was in Olivia's best interest to terminate David's parental rights and permanently place Olivia with the Fishers pursuant to Whittier Juvenile Code Section 200 because she would likely remain morbidly obese in David's care.

Whittier Juvenile Court-appointed legal custodians and social workers can consent to the prescription and administration of psychotropic medications as part of ordinary medical care. Section 300 of the Code defines "ordinary medical care" to include "mental health treatment other than inpatient psychiatric hospitalization." Only inpatient psychiatric hospitalization is explicitly excluded from the acceptable mental health treatments; psychotropic medications must be included in ordinary medical care. Appellant's contention to the contrary is based solely on his belief in the dangers of psychotropic medications.

ARGUMENT

I. THE COURT ORDER REMOVING OLIVIA FROM DAVID'S CARE AND THE TERMINATION OF HIS PARENTAL RIGHTS WERE PROPER BASED ON HIS WILLFUL FAILURE TO TREAT OLIVIA'S LIFE THREATENING OBESITY.

The Juvenile Court properly adjudged Olivia dependent under Section 100(b). (A. A-1.) The court found that Olivia had suffered, and was at substantial risk to continue suffering, serious physical harm as a result of David's repeated and willful failure to provide her with appropriate food and medical treatment. (J.A. 8.) David blatantly neglected Olivia's physical and medical needs. (J.A. 2, 3, 5, 6.) Termination of David's parental rights was appropriate under Section 200 because his repeated failure to properly care for Olivia demonstrated that she was likely to remain morbidly obese in his care. (A. A-2.) It was in Olivia's best interest to allow the Fishers to adopt her. (J.A. 7.)

A. The Department Properly Removed Olivia from David's Care Because He Repeatedly Failed To Treat Her Morbid Obesity and Co-Morbid Conditions.

Olivia's obesity and co-morbidities constituted serious imminent risk justifying her removal from her father's custody under Section 100. (A. A-1.) Prior to Olivia's removal, doctors repeatedly advised David to address Olivia's obesity and the life threatening, long-term risks associated with it, but David routinely failed to follow doctors' orders. (J.A. 1, 2, 3.) Olivia's removal was proper under Section 100(b) because of David's medical neglect and failure to provide her with appropriate food. (A. A-1.)

1. David's repeated failure to provide Olivia proper food and exercise justified her removal pursuant to Section 100.

Juvenile courts are increasingly likely to take jurisdiction for parents' failure to provide appropriate food for their obese children. *See, e.g.*, *In re G.C.*, 66 S.W.3d 517, 520-21 (Tex. App. 2002); *In Interest of L.T.*, 494 N.W.2d 450, 453 (Iowa Ct. App. 1992); *In re D.K.*, 58 Pa. D.

& C.4th 353, 361-62 (2002). This increase is due to an uptick in the childhood obesity rate, which has risen to the level of a national public health concern. Jess Alderman, et al., *Application of Law to the Childhood Obesity Epidemic*, Journal of Law, Medicine & Ethics, Spring 2007, at 90. Several child welfare departments have removed children from parents' care specifically for fostering their child's morbid obesity. *See, e.g.*, *In re G.C.*, 66 S.W.3d at 520-21; *In Interest of L.T.*, 494 N.W.2d at 453; *In re D.K.*, 58 Pa. D. & C.4th at 361-62.

In *In re G.C.*, the Texas Department of Protective and Regulatory Services ("TDPRS") removed four-year-old G.C. from his mother, F.M. 66 S.W.3d at 520. G.C. was ninety-seven pounds when TDRPS began its investigation. *Id.* After changing doctors several times, G.C.'s weight had increased to 136 pounds, culminating in his hospitalization for mild cardiac distress and respiratory problems. *Id.* TDPRS found that F.M. had inadequately addressed G.C.'s needs after doctors' orders to put G.C. on a strict diet. *Id.*

In *In re D.K.*, a five-foot three-inch tall sixteen-year-old weighing 451 pounds was removed from his parent due to his enlarged liver—a precursor to cirrhosis—hypertension, respiratory problems, insulin resistance, sleep apnea, and knee pain. Pa. D. & C.4th at 355.

In *In Interest of L.T.*, a five-foot three-inch tall ten-year-old girl weighing 270 pounds was removed from her parents and placed in residential foster care after they failed to address her obesity-causing depression. 494 N.W.2d at 452.

In re G.C., *In Interest of L.T.*, and *In re D.K.* show that when a child becomes morbidly obese with identifiable co-morbidities due to parents' provision of inappropriate food, the state can, and should, intervene. This is particularly true when parents have had the opportunities and guidance necessary to help their children, but have failed to do so.

Like the morbidly obese children above, Olivia is a victim of her circumstances. The food David provided Olivia was unhealthy and inappropriate. She subsisted on cookies, candy, and potato chips for lunch and snack, and pastries for breakfast. (J.A. 2.) David was repeatedly instructed that these foods were not proper for his daughter, and advised of healthy alternatives. (J.A. 2-3.) Olivia was a morbidly obese young woman; precedent supports her removal from David under Section 100(b) because David failed to provide Olivia with appropriate food despite the repeated warnings and remedial services the court provided him. (J.A. 2, 3, 5, 6.)

2. David's failure to treat Olivia's morbid obesity and co-morbid conditions constituted medical neglect justifying her removal.

David's failure to treat Olivia's co-morbidities constituted medical neglect under Section 100(b). Children have a right to bodily integrity and self-determination; they require appropriate medical care to protect their interests. *Parham v. J.R.*, 442 U.S. 584, 619 (1979) (affirming minors' right to a hearing prior to parents committing them to a mental hospital); *Ingraham v. Wright*, 430 U.S. 651, 673-74 (1977) (recognizing minors' liberty interest in freedom from corporal punishment based on the right to bodily integrity). Children's liberty interest creates a parental duty to provide medical treatment. *See, e.g.*, *Iowa v. Karwath*, 199 N.W.2d 147, 149 (Iowa 1972) (holding that children requiring adenoid and tonsil surgery were appropriately adjudicated dependent when parents refused to consent to surgery); *In re Hudson*, 126 P.2d 765, 788 (Wash. 1942) (en banc) (holding the parental duty to provide medical care for children is so fundamental that the decision to amputate a minor's arm cannot be transferred to the State by granting it temporary custody). The right to parental care, custody, and control of children is broad. *See, e.g.*, *Troxel v. Granville*, 530 U.S. 57, 75 (2000) (recognizing child visitation rights); *Stanley v. Illinois*, 405 U.S. 645, 658 (1972) (recognizing an unwed father's parental rights); *Wisconsin v. Yoder*, 406 U.S. 205, 233 (1972) (recognizing Amish parents' right to remove their

sixteen-year-old children from high school). Parental rights have never allowed a parent to ignore a child's medical needs. In fact, parents can be criminally prosecuted for failing to provide their children with appropriate or adequate nutrition. *See, e.g.*, *Sanders v. State,* 715 S.E.2d 124, 126-27 (Ga. 2011) (affirming parents' murder convictions for feeding their infant son a diet of soy milk and apple juice); *Com v. Cottam,* 616 A.2d 988, 993 (Pa. Super. Ct. 1992) (convicting parents of third-degree murder for their children's malnourishment).

David willfully failed to provide Olivia with an appropriate diet and opportunities to exercise. (J.A. 2-3.) David's medical neglect interfered with Olivia's ability to maintain her bodily integrity and self-determination by preventing her from keeping herself healthy.

Medical neglect cases also illustrate children's proper removal from parental custody when parents fail to treat their child's medical conditions. In *In re Stephen K.*, a juvenile court adjudicated fifteen-year-old Stephen dependent because his parents under-treated his cystic fibrosis and deprived him of adequate nutrition. 867 N.E.2d 81, 101 (Ill. App. Ct. 2007). The State's expert testified that treating cystic fibrosis requires a vitamin-rich diet and remedial medications, which Stephen's parents failed to provide despite multiple interventions. *Id.* at 86. The expert explained that cystic fibrosis sufferers could live a full life, but without appropriate medical care they had a life expectancy of thirty to forty years. *Id.* at 87. The Illinois Court of Appeals relied heavily on the expert's opinion in upholding the lower court's decision terminating parental rights. *Id.*

As with Stephen's un-treated cystic fibrosis, Olivia's untreated obesity shortens her life expectancy. She requires a specific diet, and David—like Stephen's parents—neglected multiple opportunities to provide necessary nutrition and lifestyle modifications. Like obesity, cystic fibrosis interferes with the sufferer's activity level and ability to lead a full life. However, unlike

cystic fibrosis, which has manageable symptoms and is susceptible to treatment but incurable, Olivia's obesity is completely reversible. Her poor quality of life could be wholly remedied by appropriate medical care in the form of diet and exercise. Obesity is also entirely preventable, unlike cystic fibrosis, and David was solely responsible for causing her life threatening condition. Olivia's initial removal from David's custody was a necessary but unsuccessful attempt to force him to understand the severity of Olivia's condition.

B. The Juvenile Court Properly Terminated David's Parental Rights Because He Failed To Treat Olivia's Morbid Obesity Despite Multiple Opportunities To Do So, Resulting in Serious Emotional and Physical Harm to Olivia.

Under Section 200(a), a juvenile court must find the presence of several criteria in order to terminate parental rights. (A. A-2.) First, the juvenile court must find by clear and convincing evidence that the child is a dependent of the court, as defined in Section 100, under Section 200(a)(i). (A. A-2.) Second, the court must find that a lack of proper parental care and control caused the child's dependent status under Section 200(a)(ii). (A. A-2.) Third, the court must find that the cause of the dependency is likely to continue and is not likely to be remedied under Section 200(a)(iii). (A. A-2.) Finally, the court must find by clear and convincing evidence that the ongoing cause of the dependency will likely cause serious physical, mental, emotional, or moral harm to the dependent child under Section 200(a)(iv). (A. A-2.)

David's parental rights were properly terminated pursuant to Section 200. Olivia was adjudicated dependent under Section 200(a)(i) at the first Juvenile Court hearing in March 2009. (J.A. 3.) Following that adjudication, David repeatedly failed to address Olivia's obesity and co-morbidities, illustrating his inability to provide "proper parental care". (A. A-2.) He demonstrated that this parental misconduct would continue indefinitely, subjecting Olivia to lifelong medical concerns, low self-esteem, and emotional difficulties. (A. A-2.) Termination of

David's parental rights was in Olivia's best interest, allowing her to live a healthy, active lifestyle with the Fishers. They, unlike David, were able to provide for Olivia's physical, and emotional needs. (A. A-2.)

1. David's parental rights were properly terminated after Olivia was adjudicated dependent for his failure to provide proper parental care and control as defined in Section 200(b) and (d).

The court adjudicated Olivia dependent; she clearly met the first criterion of Section 200. (J.A. 4.) To find a lack of parental care pursuant to Section 200(a)(ii), the court must consider the factors described in subsections (b) and (d) of Section 200. (A. A-3.) Considering only the relevant factors in subsections (b) and (d), there is clear and convincing evidence that David failed to provide proper parental care and control of Olivia. *Id.*

a. Olivia lacked proper parental care and control under Section 200(b).

According to Section 200(b)(iv), a juvenile court looks for evidence of "past egregious conduct by the parent toward the child . . . of a physically [or] emotionally . . . abusive nature," to find lack of proper parental care and control. (A. A-3.) Throughout Olivia's life, David refused to address her obesity and co-morbid conditions, even after repeated admonitions from medical professionals, the Juvenile Court, and the Department to do so. (J.A. 2, 3, 5, 6.) David also missed Olivia's nutritionist appointments and weigh-ins. (J.A. 5.) Soon after returning to his custody in March 2010, Olivia began gaining weight she had previously lost. (J.A. 5.) On a visit shortly after March 2010, Sonia White observed that Olivia was no longer very active. (J.A. 5.) She also found McDonald's wrappers in the trash and ice cream in the freezer. (J.A. 5.) David's repeated failure to comply with medical and judicial orders constituted egregious, physically abusive behavior.

Under Section 200(b)(v), a court must also consider "physical, mental, or emotional neglect of the child or evidence of past physical, mental, or emotional neglect . . . by the parent," to find lack of proper parental care and control (A. A-3.) After the court adjudicated Olivia dependent, David exhibited the same nonchalance towards Olivia's needs he had shown prior to her first removal. (J.A. 2.) Despite having clear, easy-to-follow instructions to provide Olivia with her prescribed diet and exercise, access to programs to help Olivia achieve her goals, and Olivia's enthusiasm for physical activity, David neglected Olivia's needs. (J.A. 4, 6.) After the court warned David at the eighteen-month hearing that it was his last chance to have Olivia returned to him, he continued to bring Olivia improper food, and missed parenting classes. (J.A. 6.) This lack of concern for, and willful ignorance of, Olivia's needs showed David's past medical neglect of his daughter and his continued harmful behavior.

b. David's conduct satisfied the criteria in Section 200(d) necessary to find lack of proper parental care and control.

To find lack of proper parental care and control under Section 200(a)(ii) where a child is not in parental custody at the permanency hearing, the court must consider the factors in Section 200(d). This includes whether the parent has failed to "(i) develop and maintain a parental bond with the child . . . (ii) provide for the care . . . of the child as required by law or judicial decree . . . and (iii) comply with the court ordered plan designed to reunite the child with the parent . . . ." (A. A-3.)

While Olivia was with the Fishers, David strove to maintain his bond with her at the expense of her health by bringing gummy bears to visits. (J.A. 6.) When Sonia White reminded David that sugary foods were inappropriate, David responded that he wanted to make Olivia feel like she was at home by giving her the food she liked from the gas station. (J.A. 6.) While

David sought to maintain his relationship with Olivia, he did so in a way that exacerbated her obesity, undermining her progress toward emotional and physical wellbeing.

When Olivia was in David's custody, he failed to properly care for and support her necessary lifestyle changes. (J.A. 5.) The Juvenile Court ordered David to emulate the Fishers' healthy lifestyle, including lots of activity and healthy food. (J.A. 5.) However, after Olivia's return to his care, David once again fed her the food she had enjoyed in the past—McDonald's and ice cream. (J.A. 5.) He added fruit to her diet, but continued to supply her with junk food, and did not take her to the nutritionist or court-ordered weigh-ins. (J.A. 5.) David did not follow the court's mandates. (J.A. 5.) Olivia gained weight in his care, highlighting his inability to provide the care and support the Juvenile Court required. (J.A. 5.)

David only partially complied with his court-ordered case plan to reunite with Olivia, pursuant to Section 200(d)(iii). (J.A. 6; A. A-3.) While Olivia was living with the Fishers, he made all of his visits, but missed two parenting classes. (J.A. 6.) Further, David's pattern of bringing inappropriate foods on visits was clearly contrary to the court's primary concern—treating Olivia's obesity. (J.A. 6.) As previously discussed, while Olivia was in David's care, he disregarded his court-ordered case plan. (J.A. 2, 5.)

David failed to demonstrate concern for, or understanding of, the imperative nature of Olivia's medical needs, and thus failed to provide proper parental care and control as required to prevent termination of parental rights under Section 200(a)(ii).

2. David demonstrated that Olivia's obesity—the cause of her dependent status—was not likely to be remedied in his care, and that it was likely to continue causing Olivia physical and emotional harm.

Section 200(a)(iii) requires a juvenile court to find that the cause of a child's dependency is likely to continue in order to terminate parental rights. (A. A-2.) A juvenile court must also

find, under Section 200(a)(iv), that the "continued cause of dependency is likely to cause serious physical [and] . . . emotional . . .harm to the child." (A. A-2.) David's willful failure to treat Olivia's obesity, and the emotional and physical harm it had already caused her, satisfy Section 200(a)(iii) and (iv).

a. Olivia's obesity is likely to continue, and is not likely to be remedied, under Section 200(a)(iii).

To terminate parental rights, a court must determine that the cause of dependency is "likely to continue" or "will not likely be remedied" under Section 200(a)(iii) (A. A-2.)

Other dependency and family courts must make similar findings before they terminate parental rights or parental custody. *See, e.g.*, *In re A.H.*, 628 S.E.2d 626, 628 (Ga. Ct. App. 2006); *Joe v. Lebow*, 670 N.E.2d 9, 16 (Ind. Ct. App. 1996). After having two children removed from her custody, the mother in *In re A.H.* repeatedly failed to follow her case plan, which required drug treatment, parenting classes, and maintaining an appropriate living situation. 628 S.E.2d at 629-31. One child suffered such severe obesity that she could not roll over or hold her head up. *Id*. The Georgia Court of Appeals, applying a statute nearly identical to Section 200, held that a juvenile court, when weighing termination of parental rights, may emphasize a parent's past bad acts when predicting his or her future propensity to harm children. *Id.* at 630.

In *Lebow*, a family court permanently placed a girl, N.D.L., in a father's custody because her mother, the primary custodian, consistently failed to address N.D.L.'s obesity. *Lebow*, 670 N.E.2d at 14. As a result of her morbid obesity, N.D.L. had developed severe depression and suicidal ideation. *Id.* When N.D.L.'s mother failed to treat either the obesity or her daughter's concomitant mental health needs, the court terminated her parental rights. *Id.*

Where parents failed to treat an infant's unexplained high insulin levels causing dangerously low blood glucose, a juvenile court ruled the child dependent. *In Interest of R.G.*, 885 S.W.2d 757, 759-60 (Mo. Ct. App. 1994). After a year and a half of evading medical treatment for their daughter, risking seizures and brain damage, R.G.'s father relented and administered her medication. *Id.* at 761. The court terminated the mother's custody of R.G. because of her ongoing failure to seek necessary medical care, and awarded full custody to R.G.'s father, who had begun to comply with R.G.'s needs. *Id.* at 759.

David, like the parents whose custody or parental rights were terminated in *In re A.H.*, *Lebow*, and *In Interest of R.G.*, has demonstrated that he is likely to continue his past behavior in failing to provide Olivia with proper medical care and proper concern for her emotional needs. Termination of his parental rights was proper under Section 200.

b. Olivia's obesity is likely to cause her serious physical and emotional harm under Section 200(a)(iv).

Under Section 200(a)(iv), the court must also find that "the continued cause of dependency is likely to cause serious physical, mental, [or] emotional . . . harm to the child," to terminate parental rights. (A. A-2.) The doctors who treated Olivia described the continuing physical maladies that Olivia faced if her obesity was not controlled, including cardiac disease, sleep apnea, polycystic ovarian disease, type-II diabetes, and cirrhosis. (J.A. 2, 3.) These co-morbidities constituted serious physical harm that would result if Olivia's obesity continued.

Juvenile courts also recognize emotional harm as sufficient to justify removal. A New York court removed fifteen-year-old Kevin from his parent's care for failing to authorize surgery to remove a large tumor from his face. *In re Sampson*, 317 N.Y.S.2d 641, 658 (1970). The court noted that though the tumor caused no imminent physical harm and did not reduce his hearing or sight, it would affect his "personality development," education, and socialization, and that it had

already nurtured his low self-concept. *Id.* at 644; *see also Lebow*, 670 N.E.2d at 14 (holding that transfer of primary custody to a father was necessary to address the minor's morbid obesity and resulting severe depression and suicidal ideation).

As in *Sampson* and *Lebow*, where courts found depression and low self-concept justified juveniles' removal, Olivia faced mental and emotional harm in the form of reduced self-concept, withdrawal from school, and bullying by classmates as a result of her obesity. (J.A. 3.) David's pattern of excusing Olivia's obesity only perpetuated her being bullied, her low self-esteem, and other emotional harm. Olivia acknowledged this at the permanency hearing, stating that the Fishers made her healthy and stopped kids from teasing her. (J.A. 7.) She was also able to stop taking the medication while in the Fisher's care. (J.A. 7.)

Termination of David's parental rights pursuant to Section 200(c) is appropriate because it is in Olivia's best interest, considering her mental, emotional, and physical needs. (A. A-3.) Olivia's best interests are served by remaining with the Fishers considering her past emotional, physical, and medical distress. The Fishers, unlike David, are willing and able to provide Olivia with a healthy, active lifestyle and have eliminated her morbid obesity and co-morbid conditions. (J.A. 6, 7.)

II. ADMINISTRATION OF PSYCHOTROPIC MEDICATION IS WITHIN THE DEPARTMENT'S RIGHT TO ADMINISTER ORDINARY MEDICAL CARE AS DEFINED IN SECTION 300 OF THE WHITTIER JUVENILE CODE.

Appellant errs in treating the Department's authorization to administer psychotropic medication to individuals in its custody as an unsettled question. The Department's administration of psychotropic medication to youth in its custody is statutorily authorized by Section 300. (A. A-4.) Section 300 states that: "(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." (A. A-4.) Section 300(c) goes on to specify that: "'[l]egal 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." (A. A-4.) In Section 300(c)(i), "[o]rdinary medical care shall mean medical examination, medical treatment including minor surgical procedures, and mental health treatment other than inpatient psychiatric hospitalization." (A. A-4.) Under the exact language of Section 300(c)(i), the Department can authorize a wide range of mental health treatments, including the administration of necessary medication.

A. Section 300 of The Whittier Juvenile Code Mandates State Officials To Administer Ordinary Medical Care to Children in Its Legal Custody.

Many states authorize a court-appointed guardian to consent to ordinary medical treatment for children in state custody. *See, e.g.*, Ala. Code § 12-15-314(f) (2011) (allowing state appointed guardians to consent to a child's ordinary medical care); Ariz. Rev. Stat. § 8-531 (LexisNexis 2011) (permitting court appointed guardians to consent to major medical care when parental rights are terminated, and ordinary or necessary medical care regardless of residual parental rights); Del. Code Ann. tit. 31, § 5101 (2011) (authorizing state appointed guardians to consent to any ordinary medical treatment). State appointed guardians must be allowed to consent to their charges' medical treatment because the state has removed these children from their parents' custody and care, placing the burden to provide proper medical care on the state. *DeShaney v. Winnebago Cnty. Dept. of Soc. Servs.,* 489 U.S. 189, 200 (1989). The State's affirmative duty to provide medical care to foster children "arises . . . from the limitation which it has imposed on [the child's] freedom to act on his own behalf." *Id*.

The State of Whittier likewise imposes a duty on legal custodians to provide children in their custody with necessary medical care; that duty is a direct extension of *DeShaney*. (A. A-4.) As inscribed in Section 300(c)(i), legal custody "includes the *duty* to provide food, clothing, shelter, education, and *ordinary medical care*, and to train and discipline" court dependents. (A. A-4) (emphasis added). The statute specifies that ordinary medical care includes "mental health treatment *other than* inpatient psychiatric hospitalization." (A. A-4) (emphasis added). When interpreting a statute, courts have a duty to ascertain and effectuate the Legislature's intent. *See People v. Sandish,* 38 Cal. 4th 858, 869 (2006). Here, the Whittier Legislature's intent was clear: a child's custodian must provide that child with ordinary medical care, including any necessary mental health treatment other than inpatient psychiatric hospitalization.

Sonia did not prescribe psychotropic medication to Olivia; she simply recommended that the Fishers take Olivia to the child psychiatrist because of concern for Olivia's mental health. (J.A. 4.) Sonia approved the medications the child psychiatrists prescribed to treat Olivia's mental health. (J.A. 4, 6.) Sonia merely performed her duty and appreciated the statutory mandate that Olivia's father appears to have ignored: a legal custodian must provide ordinary medical care to a child in his or her custody.

It is a recognized rule of statutory interpretation that specific mention of one exception to a rule exhausts the possible existence of other exceptions. *See Barnhart v. Peabody Coal Co.,* 537 U.S. 149, 168 (2003) (stating that when a statute expressly excludes an item associated with a group or series of items, an inference arises that associated items not expressly excluded from the statute were deliberately included). In Section 300, the Legislature specifically included "mental health treatment other than inpatient psychiatric hospitalization" in its definition of ordinary medical care. (A. A-4.) This explicit reference makes clear that the Legislature

intended all other forms of psychiatric treatment—except those prohibited by law, as mentioned in Section 300(c)—to be included within ordinary medical treatment. The administration of psychotropic medication is part of the State's duty, as Olivia's legal custodian, to provide her with ordinary medical care.

Appellant's contention that this Court should rely on other states' statutory definitions of ordinary medical care in order to interpret Whittier's definition defies the canons of statutory interpretation. (J.A. 11.) *See Nolan v. City of Anaheim,* 33 Cal. 4th 335, 340 (2004) (holding that courts will only use extrinsic interpretation aids such as "public policy, [and] contemporaneous administrative construction" when statutory language is ambiguous). Where, as here, a Legislature has carefully defined any potentially ambiguous terms, the court must not look to extrinsic evidence to illumine the statute's interpretation.

B. Psychotropic Medications Are Ordinary Medical Care.

Appellant contends that even if the Whittier Legislature statutorily allowed administration of psychotropic medications, this Court should nullify that interpretation because psychotropic medications are too dangerous to be considered ordinary medical care. (J. A. 11.) Although this Court should not rely on other states' statutory definitions of ordinary medical care to interpret Whittier's definition, it can—and should—look to judicial and legislative practices in other states to reaffirm that the Whittier Legislature's definition comports with national parlance.

The extent to which a given medical treatment is considered "ordinary," varies from state to state. In most jurisdictions, foster children are prescribed psychotropic medication where necessary, as part of their ordinary medical care. *See, e.g.*, Ala. Code § 12-15-314(f) (allowing state appointed guardians to authorize a child's mental health care); Del. Code Ann. tit. 31, § 5101 (authorizing state appointed guardians to consent to any ordinary medical treatment,

specifically including mental health treatment other than inpatient psychiatric hospitalization). In a few other states, psychotropic medications are only prescribed to foster children by court order or a biological parent's consent. *See, e.g.*, N. Y. Comp. Codes R. & Regs. tit. 18, § 441.22(d) (2011) (requiring written authorization from a foster child's parent or guardian for any psychological assessment or treatment); Cal. Welf. & Inst. Code § 369.5 (Deering 2012) (requiring a juvenile court order to administer psychotropic medication to a foster child). The components of ordinary medical care, and a state agent's ability to consent to ordinary care, varies from state to state. This state-specific treatment of psychotropic medication means that only case law from states with a statutory scheme similar to Whittier's has persuasive effect.

1. Statutes and relevant case law across United States jurisdictions support the Whittier Legislature's conclusion that psychotropic medications are ordinary medical care.

Appellant errs in relying on New York case law to claim that administering Olivia psychotropic medication did not constitute ordinary medical care. (J.A. 11.) Appellant uses *In Matter of Martin F.,* 820 N.Y.S.2d 759 (2006), to support his claim. In *Martin F.*, three-year-old Desiree L. was placed in foster care after the court found her mother had neglected her. *Id.* at 760. During her first four months in foster care, Desiree was fine, but after four months she began acting out despite being in a relatively stable foster placement. *Id.* at 765. In an effort to treat her, the Monroe County Department of Human Services ("MCDHS") approved Desiree's prescription for Depakote over her mother's objection. *Id.* at 761. Although Desiree's mother had signed a general medical consent form, the State of New York required the mother to sign a separate consent form in order to prescribe and administer Desiree medication. *Id.* MCDHS alleged that they had followed the protocol for overriding a parent's refusal to consent to a

child's medication, but the court found that they had not. *Martin F.,* 820 N.Y.S.2d at 773. As a result, the court found that MCDHS had violated the mother's parental rights. *Id.* at 773.

Though the facts of *Martin F.* mirror Olivia's custodial situation, New York law differs dramatically from Whittier law. Sonia authorized Olivia's medications only after her father had signed the medical consent form authorizing the Department to administer ordinary medical care, which was specifically defined to include mental health care. (J.A. 4-5.) Unlike the consent form Desiree's mother signed, which specifically stated that a separate authorization was required to prescribe and administer Desiree medication, the Whittier form explicitly authorized the provision of all ordinary medical care. (J.A. 4.) Ordinary medical care included mental health treatment other than inpatient psychiatric hospitalization. (J.A. 4; A. A-4.)

Two different doctors prescribed Olivia Depakote and Lexapro after running the requisite tests. (J.A. 5-6.) In *Martin F.*, psychotropic medications were recommended as a fourth treatment option in Desiree's treatment plan, *if* the other three options failed. *Martin F.,* 820 N.Y.S.2d at 765-66. Instead, Desiree's county worker authorized the administration of psychotropic medications as the first treatment option. *Id.* Two doctors independently prescribed Olivia Depakote and Lexapro as appropriate primary treatment options, unlike Desiree's prescriptions. (J.A. 6.)

Alaska, Delaware, Oregon, and Arizona all reference mental health care in their definitions of ordinary medical care. *See* Ala. Code § 12-15-314(f); Del. Code Ann. tit. 31, § 5101; Or. Rev. Stat. § 409.615(2) (2011); Ariz. Rev. Stat. § 8-531. Oklahoma specifically includes psychotropic medication in its definition of ordinary medical care. *See* Okla. Admin. Code 340:75-13-65(e) (2010). New York and Washington D.C. allow parents to retain residual rights until a court terminates their legal custody, and require parental authorization to administer

psychiatric treatment. *See* N. Y. Comp. Codes R. & Regs. tit. 18, § 441.22(d); D.C. Code § 16-2301(20) (2011). Different states have different definitions of ordinary medical care. There is no persuasive reason to abandon the Whittier Legislature's inclusion of psychotropic medications within the scope of ordinary medical care—a practice corroborated by Alabama, Delaware, Oregon, and many more—in favor of a narrower interpretation used only in New York or Washington D.C.

2. Judges lack the medical knowledge required to capably review prescriptions; asking them to do so wastes limited judicial resources.

Judges, although highly qualified legal decision makers, lack the medical expertise necessary to review trained medical doctors' decisions. In the exceedingly rare cases in which the United States Supreme Court has intervened in a custodial patient's recommended mental health treatment, the Court has shown great deference to legislators' and medical professionals' opinions. *See Heller v. Doe*, 509 U.S. 312, 333 (1993) (upholding Kentucky's differing involuntary commitment standards for mental retardation, "clear and convincing evidence," and mental illness, "proof beyond a reasonable doubt," as well as state allowance of family participation in commitment hearings); *Washington v. Harper*, 494 U.S. 210, 236 (1989) (upholding Washington's authorization procedures for prisoners' involuntary treatment with antipsychotic drugs); *Parham,* 442 U.S. at 619 (upholding Georgia's voluntary commitment procedures authorizing legal guardians to voluntarily commit minors in their care to inpatient mental hospitalization).

Parham illustrates the degree of deference courts should give to medical professionals' judgments. In upholding Georgia's procedures for custodial guardians' voluntary commitment of mentally ill children into state psychiatric facilities, the Court said: "the state agency having custody and control of the child *in loco parentis* has a duty to consider the best interests of the

child with respect to a decision on commitment to a mental hospital." *Id.* The Court then added: "the State may constitutionally allow that custodial agency to speak for the child, subject, of course, to the restrictions governing natural parents." *Parham,* 442 U.S. at 619. Even in a situation as serious as a child's commitment to inpatient psychiatric hospitalization, the Supreme Court affirmed states' rights to individually determine mental health regulations. *Id.*

The Supreme Court recognizes a state's ability to commit minors to inpatient mental institutions without natural parents' consent. Whittier's statute allowing legal custodians to consent only to lesser mental treatments without the natural parents' consent is undoubtedly valid. Two separate doctors, based on their independent judgments, prescribed Olivia Lexapro and Depakote. (J.A. 6.) Absent a readily apparent misuse of state legislative authority, Supreme Court precedent dictates that this Court uphold the Juvenile and Appellate Courts by finding that the State was authorized to consent to medication necessary for Olivia's health. (J.A. 1.)

In seeking judicial review of administration of psychotropic medication to foster children, Appellant is effectively asking judges either to disagree with the informed opinion of a trained medical professional, or rubber stamp the doctor's recommendation. This is less than social workers—who actually interact with patient-foster children—are able to do now, and supersedes judges' bounds as finders of fact and reviewers of law, wasting limited judicial resources.

3. If the State of Whittier wants to change the approval process for the administration of psychotropic medication to foster children, it should do so through legislative statutory amendment.

If the State of Whittier is concerned about side effects associated with psychotropic medications, that concern is properly addressed by adopting a statutory scheme like New York's or Washington D.C.'s, which require parental consent to administer medication. *See* N. Y. Comp. Codes R. & Regs. tit. 18, § 441.22(d); D.C. Code § 16-2301(20). The correct venue for a

drastic policy change, as Appellant requests, is the Legislature, not the courtroom. It is a long-recognized principle that: "[i]t is the court's task to construe, not to amend, the statute." *People v. Leal*, 33 Cal. 4th 999, 1008 (2004).

Currently, the State of Whittier has decided that the provision of ordinary medical care includes the State's ability to consent to a medical doctor's recommended prescription of psychotropic medications for minors in its care. This Court should uphold that decision, and enforce the plain meaning of Section 300 of the Whittier Juvenile Code.

CONCLUSION

David persistently failed to meet Olivia's physical and medical needs despite having multiple opportunities to do so. His lack of care constituted medical neglect sufficient to remove Olivia from his custody pursuant to Section 100. David's use of unhealthy food to bond with Olivia was harmful to her physical and emotional health, and showed that he would continue to promote her obesity. Olivia's medications were ordinary medical care under Section 300. More importantly, they improved Olivia's mental health. Termination of parental rights pursuant to Section 200, and administration of medications pursuant to Section 300 were proper because they facilitated the healthy, active lifestyle that led to Olivia's dramatic weight-loss.

Dated:
January 6, 2012

Respectfully submitted,

_____

Counsel for Appellee

APPENDIX

APPENDIX

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 is 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 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 of 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 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 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 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 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.