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Court of Appeals of Minnesota.

In the Matter of the WELFARE OF the CHILD OF J.M. and L.N., Parents.

No. A13–0992. | Oct. 28, 2013.

Mower County District Court, File No. 50JV13124.

Attorneys and Law Firms

Scott Cody, Tarshish Cody, PLC, Chaska, MN, for appellants J.M. and L.N.

Kristen Nelsen, Mower County Attorney, Aaron Jones, Assistant County Attorney, Austin, MN, for respondent Mower County.

Alice Snater, Mower County Courthouse, Austin, MN, guardian ad litem.

Considered and decided by BJORKMAN, Presiding Judge; PETERSON, Judge; and STONEBURNER, Judge.

Opinion

UNPUBLISHED OPINION

STONEBURNER, Judge.

***1** Appellants challenge the adjudication of their child, who, shortly after birth, tested positive for human immunodeficiency virus (HIV), as a child in need of protection or services (CHIPS). Because the record supports the district court's findings and conclusion that the child needs protection or services as a result of his environment, we affirm.

FACTS

Appellants L.N. (mother) and J.M. (father) (collectively, parents) are the parents of R.M–N. (child), the subject of the CHIPS adjudication challenged in this appeal. Parents live with mother's adoptive parents (grandparents), who provide housing and financial support for parents and child.[1] Grandparents routinely speak for parents and themselves, using "we" and "us" and "our" when discussing child's care with service providers. The district court found that grandparents control parents' decisions about child's medical care. Grandparents have also used media and social media to broadcast their views about the recommended HIV treatment for child. Grandparents' views are, in part, the result of their experience with mother's medical history with HIV.

At the age of approximately three months, mother, who was born in 1990 in Romania, was diagnosed with HIV. She was treated with an antiretroviral drug, AZT. After about two years of treatment, mother developed severe leg pains. Grandparents, based on their acceptance of opinions that AZT is lethal and that HIV does not cause AIDS, decided to discontinue mother's HIV treatment. Mother's doctor, who disagreed with the decision to stop treatment, reported grandparents to the applicable county department of human services. Grandparents, fearing that mother would be removed from their custody and on the advice of legal counsel, obtained a medical opinion from a Rochester Mayo Clinic doctor that mother's AZT treatment could be discontinued so long as mother's condition was monitored closely. The record is silent about any further interaction between grandparents and human services concerning mother's medical treatment. It appears that there was none.

Rather than have mother's condition monitored closely, grandparents avoided obtaining a primary health-care provider for mother. They used urgent-care clinics to "stay off the radar" and to avoid being "hounded" about getting treatment for mother's HIV. Mother testified that she has experienced no ill effects as a result of HIV.

Mother became pregnant with child in 2012 and obtained prenatal care at the Rochester Mayo Clinic. Mother filled out a medical-history form, on

which she indicated that she was not at risk for HIV. Mother participated in all recommended prenatal testing except for HIV testing. Father, who spoke with a Mayo Clinic doctor separately, told the doctor that neither he nor mother has HIV. The record reflects that if mother's HIV status had been discovered through prenatal testing, treatment would have reduced the risk of HIV transmission by mother to child from 30 percent to less than two percent.

***2** Child was born at Rochester Mayo Clinic on December 19, 2012. Because of a variety of breathing and other health problems, he was intubated and transported to the neonatal intensive-care unit. A neonatologist explained to the family that child's condition was more precarious than that of very premature babies and suggested HIV testing for the child. Mother refused consent to have child tested. She later said that she refused testing because the family already knew that the child might be HIV-positive, but she did not reveal this knowledge when testing was requested.

After additional clinic staff became involved in the case, including a pediatric infectious-disease physician, a social worker, and an attorney, mother's childhood medical history at the clinic was located, showing that mother had tested positive for HIV as an infant. Based on this information, the clinic team advised the family that both mother and child needed to be tested for HIV, that the child needed to start a preventative-medication regimen, and that this was required therapy. The team explained that if child did not already have HIV, prophylactic treatment needed to be started within the first 12 hours of life in order to keep child from contracting the virus. Mother refused consent to both HIV testing and treatment for child.

Because of the need for immediate treatment, clinic staff informed the family members that, absent their consent to the recommended testing and treatment, the clinic had no choice but to request a court order allowing child to be tested for HIV and treated as necessary. Mother continued to refuse consent. After staff left to pursue a court order, grandfather told mother that keeping custody of child should be her first priority and that she should consent to testing and treatment. Mother then consented. Prophylactic treatment started immediately, but once testing revealed that child was HIV-positive, prophylactic treatment was discontinued.

On December 26, doctors presented the family with the treatment options for child's HIV infection. The record reflects that medical literature recommends treatment for all HIV-infected infants 12 months of age or younger and emphasizes expeditious treatment due to the high risk of the virus's progression and mortality. Two treatment plans were presented to the family. The first plan involved treatment with a three-drug cocktail[2] of Nepivir, Kaletra, and Retovir (containing AZT), but could not be started until 14 days after birth. The second plan, not generally as highly recommended, did not involve Kaletra and could be started immediately. Child's primary doctor advised the family that child would benefit from starting treatment immediately and recommended the second plan. Mother and father elected the first plan, and child's treatment started under this plan when he was 14 days old.

Child was hospitalized for three weeks after birth due to his HIV treatment and complications either caused or exacerbated by his HIV infection. These complications included meconium aspiration, pneumothorax (an air bubble between the lung and chest wall, a potentially life-threatening condition), damage to the central nervous system, underdeveloped muscles, and small head size (third percentile). The primary concerns, however, were child's insufficient weight-gain and feeding issues.[3]

***3** Child was discharged from the hospital on January 10, 2013, and follow-up appointments were scheduled at Rochester Mayo Clinic for January 10, 11, 12, 14, and 15. Doctors stressed the importance of these appointments,[4] stating that if child did not gain weight, he would need to be re-admitted to the hospital.

Parents kept the first four appointments. At the January 14 appointment, mother reported that child's HIV treatment "fizzed in his mouth," but denied that he was spitting out any doses or having difficulty swallowing the medication. Although child's weight was increasing, he was not meeting his weight-gain goals, and a nutrition appointment was scheduled for January 16.

On January 15th, the family brought child to his scheduled morning weight check. But 30 minutes before the scheduled afternoon appointment with the pediatric infectious-disease team, grandfather called to report that the family would not be attending that appointment. The clinic had arranged for a pediatric infectious-disease doctor from the University of Minnesota to attend that appointment

to discuss child's HIV treatment in the event that the family moved to Minneapolis. A Mower County Health and Human Services (the county) case worker was also present to attend the afternoon appointment. Attempts to contact the family that afternoon were unsuccessful.

The family also failed to attend the nutrition appointment on January 16, and attempts to contact the family were unsuccessful. The clinic contacted the county to report the missed appointments.

On the morning of January 17, the child's primary doctor and the county case worker both attempted to contact the family without success. The case worker called again in the afternoon and spoke with grandfather, who explained that mother and father were driving child to Seattle, Washington for a second opinion. Grandfather said that the family could not reschedule the missed appointments until the following week and that father would be contacting the case worker. Later that afternoon, father contacted the case worker to say that parents and child were returning to Minnesota. The case worker told father that the district court had already granted the county's request for emergency protective-care placement.

On January 18, the protective-care order was served on mother and father at grandparents' home, and child was taken to a foster home. The foster mother immediately observed that child was wheezing, and child was taken to the hospital. Child was diagnosed with "acute failure to gain weight." He had lost 150 grams since his weight check three days earlier. He was also unable to breathe while feeding[5] and experienced episodes during which he would arch his back and wheeze. Doctors determined that these episodes were a result of aspiration of food and medicine.

Child was hospitalized from January 18 to March 7, during which time he experienced a variety of complications. He could not be fed safely by mouth and had a gastronomy tube surgically implanted into his stomach. He experienced anemia and required several blood transfusions.

***4** Child's doctors discussed with the family substituting Abacavir, which does not contain AZT, for Retovir in order to avoid any effect AZT might have had on child's anemia. Parents and grandparents expressed concern about the side effects of the new medication and also questioned whether child is HIV-positive. They ultimately consented to the recommended substitution.

Since child started treatment for his HIV infection, the amount of virus in his blood has decreased progressively. Child was discharged from the hospital on March 7 into mother's care. In the weeks prior to his discharge, mother participated in education programs about child's treatment and demonstrated administration of his medications to clinic staff.

In April, the district court held a two-day CHIPS trial.[6] After receiving testimony from child's primary doctor, the county sheriff, the county case worker, the case worker's supervisor, a county social worker, child's guardian ad litem (GAL), grandparents, and parents, the district court made detailed findings of fact and concluded that the county had established, by clear and convincing evidence, the allegations in the CHIPS petition, asserting Minnesota Statutes section 260C.007, subdivisions 6(3), (4), (5), and (9), as statutory grounds for a CHIPS adjudication. The district court stated that, without monitoring by the county and the GAL, it did not believe that either parent would continue to provide the recommended treatment to the child.

Parents moved for a new trial. The district court denied the motion, and this appeal followed.

DECISION

On appeal, mother and father argue that (1) the district court did not apply the appropriate legal standard for determining whether the child is a CHIPS; (2) if the district court applied the correct standard, it misinterpreted Minnesota Statutes section 260C.007; and (3) the district court's findings of fact are clearly erroneous and do not support a CHIPS adjudication. We disagree.

I. Standard for analyzing a CHIPS petition in district court and interpretation of statutory requirements

The county alleged that child is a CHIPS because: (1) the child "is without the necessary ... required care for the child's physical ... health ... because the child's parent ... is unable or unwilling to provide that care," Minn.Stat. § 260C.007 subd. 6(3); (2) the child is without the special care made necessary by a physical condition ... because the child's

parent ... is unable or unwilling to provide that care," Minn.Stat. § 260C.007, subd 6(4); (3) the child is medically neglected, Minn.Stat. § 260C.007, subd. 6(5); and (4) the child is in a dangerous environment, Minn.Stat. § 260C.007, subd.6(9).

Citing *In re Welfare of Child of S.S.W.,* 767 N.W.2d 723, 728 (Minn.App.2009), the district court stated that the county had to show, by clear and convincing evidence, that one or more of the statutory bases for a CHIPS adjudication is present and that the child is in need of protection or services as a result. Parents agree that *S.S.W.* articulates the correct standard by which a district court must analyze whether a child is a CHIPS.

***5** But parents argue that Minn.Stat. § 260C.007, subds. 6(3), (4), and (5), all require proof that, at the time of the CHIPS trial, the child's parent is not providing required care. Parents contend that the district court analyzed these statutes as requiring only the potential that a parent would likely withhold such care in the future. Parents' argument that the district court did not apply the standard articulated in *S.S.W.* is based on the district court's statement that the state may invoke its power to protect children "if it appears that parental decisions will jeopardize the health and safety of the child," *Wisconsin v. Yoder,* 406 U.S. 205, 233–234, 92 S.Ct. 1526, 1542 (1972), and the district court's reference to a law-review article proposing as a test for medical neglect "a showing that the child ... is at imminent risk of serious harm ... because of a mother's decision about [antiretroviral treatment]" and proof by the state that "it is offering non-experimental treatment that is life-saving or curative and for which the risks are outweighed by the benefits." Kimberly M. Mutcherson, *No Way to Treat a Woman,* 25 Harv. Women's L.J. 221, 261 (2002).

This contention also serves as the basis for parents' alternative argument that, if the district court applied *S.S.W.,* it misinterpreted the requirements of Minn.Stat. § 260C.007, subds. 6(3), (4) & (5), to permit consideration of conditions that *might* exist instead of conditions that actually exist at the time of the CHIPS trial.

We conclude that it is not necessary to address these challenges to the CHIPS adjudication because the county had to establish only one statutory ground for the adjudication, and Minnesota Statutes section 260C.007, subdivision 6(9), plainly permits the district court's consideration of conditions that will lead to future harm, including the likelihood that a parent will, because of strongly held and frequently articulated beliefs as well as past conduct, withhold from or prevent a child from receiving necessary medical care. This subdivision defines a CHIPS as:

> a child who is in need of protection or services because the child ... is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home[.]

Minn.Stat. § 260C.007, subd. 6(9). This subdivision includes past, present, and future risk due to the child's environment. *See S.S.W.,* 767 N.W.2d at 732 ("We agree that section 260C.007, subdivision 6, does not mandate proof of current abuse or neglect unless the alleged child-protection ground requires such proof.").

Parents rely on *In re Welfare of Children of N.F.,* 749 N.W.2d 802 (Minn.2008),[7] to argue that, absent the presence of criminal activity, an abuser in the home, or proof of actual mental or physical injury to a child, "courts have refused to find subdivision 6(9) proven." The relevant portion of *N.F.,* however, does not support parents' argument. There, the district court found Minn.Stat. § 260C.007, subd. 6(9) satisfied based on the same findings that it ruled had shown physical abuse under Minn.Stat. § 260C.007, subd. 6(2). *N.F.,* 749 N.W.2d at 811. Noting that the district court had made "no other findings" regarding the children's "behavior, condition, or environment" under Minn.Stat. § 260C.007, subd. 6(9), and that the district court had used an incorrect definition of physical abuse for purposes of Minn.Stat. § 260C.007, subd. 6(2), the supreme court reversed the district court's ruling that the children were CHIPS under Minn.Stat. § 260C .007, subd. 6(9). *N.F.,* 749 N.W.2d at 811–12. If the district court had made findings on the children's "behavior, condition, or environment" under Minn.Stat. § 260C.007, subd. 6(9), whether the supreme court would have read that provision as parents propose is, at best, unclear. We note, however, that the assertion that an injurious environment requires

one of the factors enumerated by parents is contrary to a plain reading of subdivision 6(9) and numerous CHIPS adjudications this court has reviewed that are not reported in published opinions.

II. Challenge to findings of fact

***6** This court is bound by a "very deferential standard of review" of factual findings in CHIPS determinations, *S.S.W.,* 767 N.W.2d at 734, and will not reverse such findings unless they are "clearly erroneous or unsupported by substantial evidence." *In re Welfare of B.A.B.,* 572 N.W.2d 776, 778 (Minn.App.1998). "A finding is clearly erroneous if it is either manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." *In re Welfare of Children of T.R.,* 750 N.W.2d 656, 660–61 (Minn.2008) (quotation omitted). When reviewing factual findings, appellate courts view the record in the "light most favorable to the findings." *Frauenshuh v. Giese,* 599 N.W.2d 153, 156 (Minn.1999).

Parents contend that the district court's findings that child's condition or environment is "such as to be injurious or dangerous" to him and that he needs protection or services as a result are clearly erroneous. Minn.Stat. § 260C.007, subd. 6(9). They argue that because mother consented to treatment and because, in parents' opinion, child did not suffer actual harm from their initial denial of testing and treatment, the county failed to prove any statutory basis for a CHIPS adjudication. And even if there is a statutory basis, parents argue that the county failed to prove that child needs protection or services as a result because the family has stated that they will continue to provide medical treatment so long as they are "legally required" to do so, despite expressing their disagreement with treatment.

But the district court did not credit parents' assertions that they will continue child's treatment without monitoring by the county and the GAL. Appellate courts defer to the district court's determinations of credibility. *Sefkow v. Sefkow,* 427 N.W.2d 203, 210 (Minn.1988). And the record amply supports the district court's finding that, absent the threat of county intervention, parents will not continue to provide the required treatment. Mother's own history is significant: once grandparents evaded county involvement with mother's treatment, they stopped recommended monitoring of her HIV infection and avoided contact with medical providers that could have led to a requirement of testing or treating mother's condition.

The district court found that mother's denial that she is HIV-positive during her pregnancy and refusal to get prenatal testing or treatment for HIV increased child's risk of infection from less than two percent to 30 percent. This finding bears on the risk posed to child by his environment. During labor and after giving birth, mother refused consent for child to be tested and treated for HIV, endangering his life. Only with the threat of county involvement did mother consent to testing and treatment. And even then, the family missed two mandatory follow-up appointments and planned to miss other appointments so that they could drive with child to Seattle to seek an opinion that would relieve them of a legal requirement to provide treatment recommended by child's Minnesota doctors.

***7** The record reflects that child's HIV infection and associated ailments puts his health in an exceedingly precarious position. There is evidence that even a five-percent noncompliance with his treatment regimen could have severe consequences and that, without treatment, child faces a significant risk of AIDS or death within 12 months. The district court's findings and conclusions that child is a CHIPS under Minn.Stat. § 260C.007, subd. 6(9) because he is in an environment that is dangerous to his health and that child is, as a result, in need of protection or services of the court are fully supported by the record.

Affirmed.

Footnotes

1 Father also maintains a residence in Minneapolis.

2 The record reflects that HIV is treated with a combination of medications to reduce the potential for the virus to develop resistance.

[3] Child had trouble swallowing, and liquid would aspirate into his trachea rather than going down his esophagus. Along with breathing issues, the child's high risk of pneumonia was particularly concerning, especially with his compromised immune system.

[4] Child's discharge papers stated that "if the family fails to show up for a weight check, fails to return to the hospital if he has significant weight loss and/or fails to make the Tuesday, January 15 outpatient appointment, this will be an indication to Social Services."

[5] The oxygen level in child's blood decreased during feeding, indicating that he was having trouble getting oxygen while feeding.

[6] In late February, the district court adopted the recommendations of the GAL and the county to return custody of the child to mother subject to county supervision.

[7] The court in *N.F.* rejected the county's allegation that paddling a 12–year–old boy as punishment for misbehavior constituted malicious punishment of a child and satisfied the requirements for a CHIPS adjudication under Minn.Stat. § 260C.007, subd. 6(2)(i). 749 N.W.2d at 811–12.