STATE OF MICHIGAN

COURT OF APPEALS

In re Z. X. WITTEN, Minor.

UNPUBLISHED
May 18, 2017

No. 334332
Wayne Circuit Court
Family Division
LC No. 09-491302 - NA

Before: RIORDAN, P.J., and RONAYNE KRAUSE and SWARTZLE, JJ.

PER CURIAM.

Respondent appeals by right the trial court's order terminating her parental rights to her biological son, ZX, under MCL 712A.19b(3)(b)(*i*), (b)(*ii*), (g), and (j).We affirm.

The instant case begins in August 2015 with the tragic death of OA, respondent's biological daughter, while in respondent's care from diabetic ketoacidosis; however, the facts relevant to the resolution of this appeal date to 2009. In 2009, Children's Protective Services (CPS) received a referral that OA had been admitted into Mott Children's Hospital where she was diagnosed with diabetes. During her physical examination, doctors found bruises on her back, buttocks, legs and thighs. CPS determined that the bruises were the result of physical abuse. OA was eventually returned to respondent's care after respondent completed a treatment plan. Petitioner referred respondent to a reunification program to provide in-home services, offered respondent services focused on caring for children with Type I diabetes, and encouraged respondent to seek additional help.

In 2010, CPS asked Dr. Dawn Dore-Stites, a licensed psychologist in the Pediatric Diabetes Clinic at the University of Michigan, to assess OA's family situation due to concerns about OA's elevated blood glucose levels. From April 2012 through June 2015, Dr. Dore-Stites conducted 26 psychology sessions with OA at the clinic and respondent aimed at helping respondent deal with her "family stressors" and instruct her on how to monitor and control OA's diabetes. Dr. Dore-Stites repeatedly told respondent that it was her duty to monitor OA's blood glucose levels. Dr. Dore-Stites reported that, at times, she witnessed "pretty low parental monitoring," which eventually caused the clinic to deny respondent's request for an insulin pump. According to Dr. Dore-Stites, OA appeared to be administering the majority of the insulin shots herself.

In 2014, OA was twice hospitalized for diabetic ketoacidosis. The diabetes team reported these hospitalizations to CPS and, shortly thereafter, respondent left the program, switching

OA's care provider to Dr. Jaclyn Bishop.[1] Dr. Bishop advised respondent that she needed to personally test OA's blood glucose levels four times per day and administer every shot of insulin, but respondent told her that doing that was "difficult." At each visit with Dr. Bishop, respondent and OA brought with them a record of OA's levels. Dr. Bishop testified that she believed some of these records were falsified because they were not "reasonable" in light of OA's recently high levels. Dr. Bishop appears to have given respondent a binder with instructions for OA's care and, according to Dr. Bishop, respondent was to call her if OA became lethargic, unresponsive, had difficulty breathing, or was hallucinating.

OA's levels were very high in April 2015, causing Dr. Bishop to shorten the length of time between OA's appointments. Respondent and OA, however, missed their next appointment on July 29, 2015. On August 11, 2015, respondent called her close friend, Alexia Follett, to ask if OA could visit with Follett and Follett's stepdaughter for the night. Follett agreed and respondent dropped OA off at Follett's residence. OA eventually stayed five nights with Follett, returning home with respondent on August 16, 2015.

On the morning of August 14, 2015, OA started vomiting and Follett called respondent. Respondent told Follett to give OA an injection and have her drink water and, if OA's numbers did not decrease, to give her another injection. The numbers did not go down and OA become "floppy" and stated that her stomach and back hurt. Later that morning, Follett called respondent and asked her to bring water bottles to her house because she was running out and did not want to leave OA alone. Respondent told Follet that she had many things to do before she could drop off any water.

When respondent eventually did drop off the water, OA was lying on the living room floor, wanting to sleep, and arguing with Follett, who wanted her to get up. Respondent brought OA to a bedroom and gave her an injection. OA's levels went down a little, but she did not feel any better. Despite this, respondent told Follett that she had a date that night and a wedding the next morning, so she could not take OA home with her.

The next morning, August 15, 2015, Follett called respondent because she was running out of OA's medicine. When respondent dropped off the medicine, OA was lying down on the floor and would not get up. Respondent told Follett to keep giving her water and OA stayed that night with Follett. OA's condition worsened that night. Follett tried calling respondent, and, when respondent did not answer her phone, left respondent a voicemail. Follett also texted respondent to tell her that OA would not eat and needed more medicine. Respondent never answered. OA vomited again on Sunday morning and her monitor read "HI." OA continued to vomit, was very weak, and held high levels for more than an hour. Follett called respondent and told her about OA's condition.

[1] Respondent and OA continued counseling sessions through Dr. Dore-Stites, although not receiving diabetes treatment from the clinic.

When respondent arrived several hours later, she began yelling at OA that she could not have a normal life, real job, or love life, and that "she couldn't do anything because there's [OA]." OA was still sick at this time and respondent tried to get her to shower and brush her hair. Follett remembers respondent being " rough" with OA. Respondent then pushed OA hard enough that OA went out the front door, ran into the railing on the front porch, and sat down. Respondent yelled at OA that she wished she would "just die," that she wanted to put OA in a home, and that OA's dad could have her. Respondent then brought OA back into the house and Follett and respondent helped OA change into some cooler clothes. Follett remembers that, while she was assisting OA, OA made an "odd comment" that she did not know "what five pesos meant" and seemed "spacey."

Follett reported to police that respondent told her that she had to "get this brat home," and that OA struggled to walk to the car when the two left around 2:00 pm. Respondent's aunt, Valeria Farrer, testified that she arrived at respondent's home around 4:00 pm that day. When she arrived, respondent was not home, but several other family members were. Around 4:30 pm, Farrer noticed OA lying on the floor and took a cellphone picture of her. Respondent returned between 5:00 pm and 5:30 pm and OA was still on the floor. Respondent or a family member injected OA with insulin twice and monitored her levels. Farrer left for dinner shortly thereafter. When she returned, OA was sitting on the couch with her eyes half open. Noting that she had "never seen anything like this," Farrer took a photo of OA and sent it to her granddaughter. When her grandaughter saw the photo, she called CPS.

Respondent's friend, Holly Howard, visited respondent at her home on the night of August 16, 2015, but respondent would not let her into the house because of OA's condition. At some point, respondent's aunt emerged from the home and showed Howard a picture of OA. Howard testified that OA looked pale and had dark rings around her eyes, and that she advised respondent to have OA evaluated by a physician. Respondent stated that she did not have the time or money for that.

Eventually OA completely lost consciousness and EMS was dispatched to respondent's home. When EMS personnel arrived, OA was unconscious on the floor, surrounded by a pool of brown liquid, and there was a woman standing over OA trying to scoop the liquid out of her mouth. The paramedics started CPR, eventually found a rhythm on the monitor, and took OA to the hospital. OA died on August 17, 2015, from what was determined to be diabetic ketoacidosis.

Dr. Carl Schmidt, chief medical examiner for Wayne County, explained that ketoacidosis results from a lack of insulin in a diabetic's blood stream, and described the ailment as follows:

> Ketoacidosis does not kill you instantaneously. Before you go, before you die as a result of not taking insulin you will become comatose. This is a process that takes about two or three days to evolve. The general sequence is you start hyperventilating. Some, most patients report vomiting. The vomiting can be fairly severe, and then eventually you will lapse into a coma. And the duration of the coma varies but it's at least a number of hours. Most, if not all diabetics who die[] from ketoacidosis will be comatose for a number of hours before you die.

Petitioner filed an original complaint, on October 23, 2015, seeking termination of respondent's parental rights to her biological son, ZX. Following a trial, the trial court terminated respondent's rights to ZX under MCL 712A.19b(3)(b)(*i*), (b)(*ii*), (g), and (j). Respondent appeals several aspects of that order.

Reunification Services Are Not Required When Termination is the Agency's Goal. On appeal, respondent first contends that the trial court clearly erred in terminating her parental rights where the court ordered reasonable efforts for reunification but the Department of Health and Human Services (DHHS) made no reunification efforts. "Generally, reasonable efforts must be made to reunite the parent and child[] unless certain aggravating circumstances exist." *In re Moss*, 301 Mich App 76, 90-91; 836 NW2d 182 (2013); MCL 712A.19a(2)(a). Petitioner, however, is not required to provide reunification services when termination of parental rights is the agency's goal. *In re Moss*, 301 Mich App at 91.

In this case, petitioner sought termination of respondent's parental rights in the initial petition and respondent was therefore not entitled to any reunification services. Despite this, the record shows that petitioner was providing respondent with numerous services before the initial petition to terminate her parental rights in order to prevent the removal of both ZX and OA from her care, including 26 outpatient psychological sessions and follow-up services focused on care management and planning. That respondent failed to benefit from those services clearly necessitated the petition now before us. Accordingly, we find no error in any purported failure of petitioner to provide services after petitioner filed its petition for termination.

The Trial Court Properly Terminated Respondent's Parental Rights. Next, respondent argues that the trial court clearly erred in finding clear and convincing evidence to terminate her parental rights.

First, respondent argues that termination under MCL 712A.19b(3)(b)(*i*) and (b)(*ii*) was improper because petitioner did not prove that she engaged in an act—as opposed to a failure to act—causing injury to OA or ZX. To terminate a parent's rights under these subsections, the trial court must find, by clear and convincing evidence that:

> The child or a sibling of the child has suffered physical injury or physical or sexual abuse under 1 or more of the following circumstances:
>
> (*i*) The parent's act caused the physical injury or physical or sexual abuse and the court finds that there is a reasonable likelihood that the child will suffer from injury or abuse in the foreseeable future if placed in the parent's home.
>
> (*ii*) The parent who had the opportunity to prevent the physical injury or physical or sexual abuse failed to do so and the court finds that there is a reasonable likelihood that the child will suffer injury or abuse in the foreseeable future if placed in the parent's home. [MCL 712A.19b(3)(b).]

Although there was ample evidence of respondent's direct physical abuse of OA, the trial court appears to have concluded that respondent's failure to provide proper medical attention for OA supported termination of her parental rights to ZX under subsections (b)(*i*) and (b)(*ii*). We

need not reach the question whether respondent's failure to seek proper medical attention for OA constituted the type of "abusive contact" to which subsections (b)(*i*) and (b)(*ii*) have been applied, *In re LaFrance*, 306 Mich App 713, 725; 858 NW2d 143 (2014), because we find that subsections (g) and (j) independently support termination of respondent's parental rights, *In re Trejo Minors*, 462 Mich 341, 360; 612 NW2d 407 (2000).

As to subsections (g) and (j), respondent also argues that the trial court clearly erred in finding clear and convincing evidence to support termination. She claims that there was no evidence that she had ever improperly cared for ZX or harmed him in any way and that the doctrine of anticipatory neglect was inapplicable to this case. We disagree.

To terminate a parent's rights under subsection (g), the trial court must find, by clear and convincing evidence, that "[t]he parent, without regard to intent, fail[ed] to provide proper care or custody for the child and there is no reasonable expectation that the parent will be able to provide proper care and custody within a reasonable time considering the child's age." MCL 712A.19b(3)(g). Similarly, a trial court may terminate a parent's rights under subsection (j) when "[t]here is a reasonable likelihood, based on the conduct or capacity of the child's parent, that the child will be harmed if he or she is returned to the home of the parent." MCL 712A.19b(3)(j).

While, on their face, subsections (g) and (j) may appear to apply only in the situation where the parent neglects the child the rights to which are sought to be terminated, the doctrine of anticipatory neglect recognizes that "[h]ow a parent treats one child is certainly probative of how that parent may treat other children." *In re AH*, 245 Mich App 77, 84; 627 NW2d 33 (2001) (internal quotation marks and citation omitted). Courts properly apply the doctrine to "guarantee the protection of a child" based on the parent's previous conduct with another child, when "there is good reason to fear that the second child . . . will also be neglected or abused." *Id*. (internal quotation marks and citation omitted). Indeed, the doctrine of anticipatory neglect has been applied in cases involving subsections (g) and (j).[2]

Respondent references *LaFrance*, 306 Mich App at 730-731, for the proposition that the doctrine of anticipatory neglect is inapplicable in situations where differences in the children's ages and needs, especially medical needs, present a factual situation from which no inferences can be drawn between the parent's neglect of one child and the parent's ability to care for another child. Respondent argues that, because ZX is only nine years old and does not share his fourteen-year-old sister's diagnosis of diabetes, that the doctrine of anticipatory neglect is inapplicable to this action. We disagree.

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[2]See *In re Powers*, 208 Mich App 582, 592-593; 528 NW2d 799 (1995), superseded on other grounds by MCL 712A.19b(3)(b)(*i*) (applying anticipatory neglect in the context of subsection (g)); See *In re Foster-Rimson*, unpublished opinion of the Court of Appeals, issued July 14, 2016 (Docket No. 330938), p 4 (applying anticipatory neglect in the context of subsection (j)).

Concerning the children's differing ages, in *LaFrance*, 306 Mich App at 731, the trial court held that the doctrine of anticipatory neglect was inapplicable where the respondent's "three older children ranged in age from five to twelve years at the time of termination, and, thus, did not share their infant sister's medical vulnerabilities or inability to articulate personal needs or discomforts." In this case, however, ZX is substantially younger than OA was at the time of her death. ZX is therefore likely less able to articulate his needs to either his mother or any teacher, officer, fireperson, or other emergency personnel than OA. Moreover, while respondent may have faced different, and possibly more complicated, parenting challenges because OA was a teenager, ZX will soon enter his teenage years, and respondent would need to address those challenges with ZX as well.[3] Accordingly, the differences in age between ZX and OA is insufficient for this Court to find that this case presents "the unusual circumstance[]" in which "the doctrine has little bearing." *Id*. at 730.

Next, regarding OA's medical needs, respondent essentially asks this Court to believe that OA's diabetes—an ailment of which ZX does not suffer at this time—was the sole reason that respondent was unable to provide for OA's proper care and guidance. That, we cannot do. Although we recognize that OA's diabetes presented some unique challenges, respondent's actions throughout petitioner's involvement, and especially leading up to OA's death, demonstrate not the inability of a well-meaning parent to cope with a child's complicated medical issues, but rather a steadfast disregard to undertake any parental responsibilities.

Respondent dropped OA off at a friend's house for five days while she went on dates, ran errands, and attended social gatherings. During this time OA became seriously ill. Although her condition continued to decline to the point where OA could barely walk or stand or hold coherent conversation, respondent repeatedly placed her social priorities above her daughter's health. Respondent refused to even drop off OA's medical supplies or water, or otherwise assist in OA's care until the aforementioned errands or social events had concluded. When OA eventually became so frail that respondent had no choice but to pick OA up, respondent verbally abused OA, telling OA that she was the reason that respondent could not have a normal love, social, or work life. Respondent called OA a "brat" and other names and went as far as to tell OA that she wished that she would die, that she was going to find another place for her, and that she could be her father's problem.

Moreover, respondent's abuse of OA did not stop at mere words, no matter how emotionally scarring those words could be. Despite OA's fragile state, when respondent picked her up, she purportedly smacked her in the face, pushed her through a doorway and onto a bench outside, and was otherwise "rough" with her. This abuse is consistent with a 2009 CPS investigation that determined that OA was being abused after several bruises were found on her body.

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[3] To the extent that ZX's young age could have afforded respondent an opportunity to correct her parental deficiencies before ZX reached his potentially challenging teenage years, as is shown throughout the record, respondent's unwillingness to prioritize her parental responsibilities over her social life leaves us with little belief that respondent would avail herself of that opportunity.

Finally, concerning respondent's decision not to contact EMS or OA's doctor, or to otherwise procure medical attention for her, respondent asks this Court to believe that she simply did not understand OA's dire situation. The record is clear, however, that respondent has had at least five years of exposure to diabetes treatment. Further, OA was previously hospitalized for diabetic ketoacidosis. OA's doctor provided respondent with a binder with instructions for OA's care and specifically advised respondent to call her or EMS if respondent's condition worsened. At least one of respondent's friends urged her to take OA to a physician. After seeing just a picture of OA's condition, another party contacted CPS. Respondent steadfastly refused to seek medical care for OA, and eventually OA died as a result. In fact, there is evidence in the record that, after OA's death, respondent attempted to cover up the extent of her refusal to seek care for OA, even going so far as to try to plan the cover up at OA's funeral.

Accordingly, the trial court did not clearly err in concluding that the primary cause of OA's death was not the inability of a well-meaning parent to medically care for a child with diabetes. Rather, OA is now deceased because respondent refused to assume sufficient parental responsibilities, and she prioritized her social life over her daughter's well-being. Although ZX does not share his sister's medical affliction, he does share her need for proper parental guidance and support. Indeed, at nine-years-old, ZX may be more dependent on this guidance than his sister was. Thus, we conclude that the trial court properly found grounds to terminate respondent's parental rights to ZX under subsection (g) and (j). Given respondent's unwillingness to assume parental responsibilities, we also conclude that termination of respondent's rights was in ZX's best interests.[4]

Affirmed.

/s/ Michael J. Riordan
/s/ Amy Ronayne Krause
/s/ Brock A. Swartzle

[4] Respondent argues that the trial court erred in its best-interest determination because the trial court did not individually consider the best interests of ZX. See *In re Olive/Metts*, 297 Mich App 35, 42; 823 NW2d 144 (2012). ZX, however, was the only child subject to the petition and was therefore the only focus of the trial court's best-interest determination. Accordingly, we consider respondent's argument to be a restatement of her argument that the doctrine of anticipatory neglect does not apply to the facts of this case. Finding that the doctrine does apply, we dismiss this claim of appeal.