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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

S. C.,

Petitioner;

v.

THE SUPERIOR COURT OF ORANGE COUNTY,

Respondent;

ORANGE COUNTY SOCIAL SERVICES AGENCY et al.,

Real Parties in Interest.

G059051

(Super. Ct. No. 17DP0304A)

O P I N I O N

Original proceedings; petition for extraordinary writ to challenge an order of the Superior Court of Orange County, Antony C. Ufland, Judge. Petition granted.

Sharon Petrosino, Public Defender, Seth Bank, Assistant Public Defender, and Brian T. Okamoto, Deputy Public Defender, for Petitioner.

Leon J. Page, County Counsel, Karen L. Christensen and Aurelio Torre, Deputy County Counsel, for Real Party in Interest.

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Orange County Social Services Agency (SSA) initiated this case because the parents of dependent child, M. L. (daughter), failed adequately to care for her medical needs. At the 18-month review hearing, the court concluded that returning daughter to either parent would create a substantial risk of detriment to daughter's physical well-being. (Welf. & Inst. Code, § 366.22, subd. (a)(1).)[1] Petitioner S. C. (mother) challenges the juvenile court's order terminating reunification services and setting a section 366.26 permanency planning hearing. Mother's petition contends there is insufficient evidence in the record to support this order. (See Cal. Rules of Court, rule 8.452.)[2] We agree and grant the petition.

FACTUAL BACKGROUND AND PROCEDURAL HISTORY

Pre-dependency Medical Issues and Care of Daughter

Mother faced extraordinary challenges at the time of daughter's birth. She dropped out of school after her junior year in high school and gave birth to a son around that time (he has not been made the subject of a dependency proceeding). About a year

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[1] All statutory references are to the Welfare and Institutions Code.

[2] Daughter's father, Ma. L. (father), did not file a writ petition challenging the court's rulings at the 18-month review. This opinion is therefore addressed solely to mother's rights.

later, daughter was born. Mother was 17 years old at the time of daughter's birth. Mother was not married to father.

Four months after daughter's birth, a terrible incident occurred. Father placed daughter on a pillow to sleep, but returned to find her face down and unresponsive. Daughter was revived. But testing indicated she had suffered brain damage. Assistance was provided to parents to obtain Medi-Cal benefits, public nursing assistance, and Regional Center programming. At the time, SSA concluded no abuse had occurred and no dependency proceedings were initiated.

Daughter suffers from epilepsy. According to her treating neurologist, the incident described above is the "presumed reason" for daughter's condition. "The circumstances around the event were unclear and were investigated, but [left] suspicions in [the neurologist's] mind about the care that [daughter] received as an infant."

In early 2016, daughter had a follow-up appointment with the neurologist. Mother "informed [the neurologist] that for 3 months [daughter] had been experiencing possible seizures, but [mother] did not call the office or talk to her pediatrician. [Daughter was admitted for testing] three weeks later, which revealed infantile spasms, a more severe form of epilepsy. She was treated . . . and improved, with resolution of the infantile spasms. . . . Concurrently, the phenobarbital level was 4, meaning that [daughter] was not getting the medication [prescribed at that time]. [Mother] said that [daughter] was spitting it out and that [mother] was having trouble [with daughter] taking it. Trusting mom, [the neurologist] changed [the prescription] to Topamax in hope of compliance. [The neurologist] explained the risks multiple times of [daughter] developing Lennox-Gastaut syndrome (LGS), a serious form of epilepsy, if [the parents] didn't get the medication in her. [The neurologist's] worst fear would be LGS that was intractable to treatment (continued to have seizures despite taking medication)."

A May 2016 SSA report deemed neglect allegations to be inconclusive. The report indicated "that the parents stopped giving [daughter] her epilepsy medication

because it made her sleepy. The parents suddenly stopping the medication to [daughter] placed [her] at increased risk of seizures, status epilepticus, and withdrawal symptoms. The parents also failed to take [daughter] to a scheduled neurology appointment. The parents have previously been informed about the severity of [daughter's] condition and the importance of compliance. The mother was further educated on the importance of medication administration. She agreed to accept Public Health community services. The mother signed a safety plan and agreed to give [daughter] all her prescribed medications."

In October 2016, another SSA report found general neglect accusations against mother to be substantiated. Mother had missed several appointments for daughter at the Regional Center. Mother was overwhelmed and agreed to work with service providers to facilitate care for daughter.

In February 2017, daughter was taken to the emergency room due to a six-minute seizure, requiring cardio-pulmonary resuscitation. Per the treating neurologist's notes, mother initially claimed she stopped giving daughter her Topamax anti-seizure medication because daughter "screams when she takes it." Mother then "changed her story" to state that mother did administer the medication, and daughter suffered headaches and cried after taking the medicine. But the Topamax "level at the time was undetectable. It was at this time that [the neurologist] began to understand that [mother] was non-compliant. And [she] did not understand [daughter's] best interest. Soon after that last visit, [daughter] began having a recurrence of seizures, likely tonic seizures [rather than mere] epileptic spasms. These seizures [indicated to the neurologist] that she was developing [Lennox-Gastaut syndrome], and that mom was not likely giving her the medication. Her level of Topamax in April 2017 was [at a reasonable level] while admit[ted] in the hospital and nurses were giving medication."

The social worker reported that prior to the February 2017 hospital admittance, mother "received Voluntary Family Services on behalf of [daughter] for the [preceding] five months. During this time, the mother has been described as being

difficult to engage and unreceptive to services. She has also failed to obtain proper medical treatment for [daughter] and has failed in providing [daughter] with her seizure medication. The mother does not appear to understand the severity of [daughter's] condition as evidenced by her abruptly ceasing to provide [daughter] with her medication."

Commencement of the Dependency Action, Initially a Noncustodial Case

In March 2017, SSA filed a noncustodial petition and detention report initiating this dependency action. The petition alleged parents failed to protect daughter from physical harm (§ 300, subd. (b)(1)) by not consistently providing daughter with required medications and care. The petition also alleged mother had a criminal history including robbery, battery, and petty theft convictions arising out of a single incident, but this criminal history was not relied on by the court or directly tied to daughter's medical issues throughout the dependency case.

Mother stated she understood the gravity of the situation and the importance of administering daughter's anti-seizure medication. Mother insisted she provided the medicine to daughter, but was concerned about the side effects. Mother agreed to participate in services and cooperate with SSA. But mother indicated she was overwhelmed with daughter's medical appointments already and expressed uncertainty regarding her ability to "balance attending additional services."

Pursuant to the stipulation of the parties at the detention hearing, the court ordered daughter to remain in the custody of her parents, subject to strict conditions pertaining to her care. Conditions included maintaining a written log of all doses administered, attending all scheduled medical appointments, and meeting face-to-face with SSA agents at least three times per week.

Mother "continued to have a difficult time appropriately meeting [daughter's] medical needs." A social worker opined mother was "aware" of daughter's

condition but was "overwhelmed" by her responsibilities. SSA agents highlighted additional challenges in mother's life at that time: she spoke only Spanish; father did not contribute to caring for daughter or son (mother was no longer involved with him romantically but received some economic support); maintaining two jobs at a restaurant and cleaning houses; caring for an ailing mother; and facing a fear of deportation.

Social worker visits to mother's residence demonstrated mother's failure to care properly for daughter in mid-2017. During a May 16, 2017 visit, mother stated she had run out of medicine the night before. The social worker travelled to the pharmacy to obtain medicine for daughter, but there were no authorized refills. Mother finally obtained a refill on May 18. The next week, another visit revealed that daughter had missed her medication four days in a row before mother refilled the prescription. Mother then promptly lost daughter's diaper bag, which contained the refilled prescription and she had to scramble once again to refill the prescription. Mother did not have her medication log available at a June 20, 2017 social worker visit. Mother failed promptly to obtain medical care for a bacterial infection on daughter's thigh during the summer of 2017.

Nevertheless, by the September 2017 jurisdictional/dispositional hearing, SSA determined that mother (for the most part) was meeting the conditions set for her by the court regarding medicating daughter and taking daughter to medical appointments. At an August 30, 2017 appointment, the neurologist had no concerns with daughter's care. Mother was consistently keeping a journal tracking medication provided to daughter.

Mother "submitted" on the SSA reports at the jurisdictional/dispositional hearing, declining to contest the evidence in those reports or present her own case. The court found count 1 of the dependency petition to be true. The court declared daughter to be a dependent of the court (§ 360, subd. (d)), and adopted SSA's recommendation to allow mother to retain custody and receive family maintenance services. The court

approved services including counseling, parental education, and support group sessions. No appeal was filed.

In November 2017, mother took daughter to the hospital. Daughter suffered seven seizures on the day of admission. Tests revealed "frequent tonic seizures and a Lennox Gastaut pattern." Mother was ordered to return weekly for testing of therapeutic drug levels.

In December 2017, SSA expressed concerns mother was not complying with her instructions. "It could not be determined if [daughter's] low medication levels were due" to mother taking daughter "to get lab work done during different times of the day or [if daughter] was not being administered the medication."

Removal of Daughter from Mother's Custody

On March 6, 2018, the court held a six-month review hearing of the family maintenance case. Agreeing with the recommendations of SSA, the court continued family maintenance services and set a 12-month review hearing for August 2018. SSA concluded it was in daughter's best interest to stay with mother. Daughter had not missed any appointments. Mother had established a regimen of cell phone reminders to administer medication to daughter three times per day. Mother also maintained a log of medicine administration, which she shared with social workers. The treating physician was aware that daughter was suffering from one to two minor seizures per week. He prescribed two medications to be taken three times a day and weekly lab visits to monitor medication levels in the bloodstream. Mother maintained a suitable residence for daughter. Mother avowed that her top priority was her children. Mother pursued her educational and therapy programs. Father was not present in mother's life. Daughter was developing: eating by herself, running, jumping, walking backward, playing with her brother, watching television, and speaking (about 50 words in Spanish).

On March 15, 2018, daughter was hospitalized due to lower medication test results. Over the prior three weeks, daughter's blood level of anti-seizure medication had dropped from 118.1 to 32.9. Interviewed by SSA, mother explained that daughter did not like the taste of the medication and had been refusing it or throwing it up since March 6. A social worker confirmed that she had observed daughter spitting up the medication on one occasion. Maternal grandmother agreed this problem existed. A nurse also confirmed that daughter refused to drink apple juice when she was aware the medication had been hidden in the drink. Once daughter was detained, her institutional caretakers initially struggled to get daughter to ingest the medicine until they began adding it to soda.

Mother conceded she should have immediately sought help after daughter began spitting up the drug. Mother's claims that she had called the neurology clinic were contradicted by the clinic. Mother accepted responsibility for not giving daughter her medicine.

In light of these new circumstances, SSA detained daughter and filed a section 387 supplemental petition. SSA emphasized its continuing concern with mother's ability to administer medication, attend necessary appointments, and generally oversee daughter's medical needs. SSA cited mother's history of noncompliance and fluctuating medicine levels.

On May 2, 2018, the court found allegations made in the section 387 petition to be true and removed daughter from mother's custody. The court ordered reunification services for mother. No appeal was filed.

Brief Procedural History of the Reunification Period

To contextualize our recitation of additional evidence considered at the 18-month review, we first provide a brief procedural history of the dependency case in the reunification period.

In October 2018, the court held the six-month review and concluded that returning daughter to parents would present a substantial risk of detriment to daughter's safety pursuant to section 366.21, subdivision (e). But the court continued family reunification services, finding there was a substantial probability of return within six months. No appeal was filed.

In May 2019, the court held the 12-month review. The court concluded that returning daughter to parents would present a substantial risk of detriment to daughter's safety pursuant to section 366.21, subdivision (f). But the court continued family reunification services, finding there was a substantial probability of return within six months. No appeal was filed.

A contested 18-month review began in March 2020 and concluded in April. It was originally scheduled to begin in September 2019, but was continued on several occasions. This hearing resulted in the order challenged by the instant writ petition.

Additional Context—Custody of Daughter in the Reunification Period

As set forth above, Mother retained custody of daughter from May 2015 (birth) until March 2018. From March 21 through April 23, 2018, daughter resided at Orangewood Children and Family Center (Orangewood). From April 23 to May 25, 2018, daughter lived with paternal grandparents; they decided they were incapable of providing adequate care and returned daughter to the custody of SSA. There were no other relatives or other persons available to provide foster care for daughter.

From May 25, 2018 to mid-June 2018, daughter resided at Orangewood. From mid-June 2018 to May 2019, daughter was placed with licensed foster caregivers. From May 2019 to July 3, 2019, daughter was back at Orangewood because the foster caregivers could no longer care for daughter because of family commitments. Attempts to find a new foster parent failed at this time.

From July 3 to October 30, 2019, on SSA's recommendation, daughter was in the custody of mother for a trial visit. Evidence pertaining to this trial return proved particularly important to deciding whether it was safe to return daughter to mother's custody at the 18-month review hearing.

After the trial visit ended, daughter briefly resided in a temporary foster home until November 8, 2019, but this placement failed because the caregiver was overwhelmed by daughter's medical care. Daughter resided at Orangewood from November 8, 2019 until January 29, 2020. Because of daughter's medical needs, SSA struggled to find a suitable foster parent. Finally, daughter resided at yet another foster home in San Bernardino County from January 29, 2020 until the 18-month review hearing.

Evidence from the Reunification Period Considered at 18-month Review

Nearly five years old by the time of the 18-month review, daughter has serious health problems that could result in her death if attended to inadequately. Since 2017, daughter has been diagnosed with Lennox-Gastaut syndrome, a severe form of epilepsy. This is a permanent condition, treatable but not curable. It results in seizures, developmental delay, and intellectual disability. In the treating neurologist's opinion, it is possible that this severe form of epilepsy was caused by parental noncompliance with administration of medication following daughter's early hospitalization as an infant, but it is also possible "this could have been the natural course of her disease."

Daughter has suffered from seizures throughout the dependency case. At her most recent April 2020 appointment, daughter's caretaker reported she is suffering one to three seizures per day. It is possible daughter will suffer seizures and require medication the rest of her life. In September 2018, a psychologist rated daughter's cognitive abilities in the "poor" range for her age.

The evidence presented at the contested 18-month review hearing consisted of SSA reports (including the material recited above and new information), as well as the testimony of three witnesses (the social worker, daughter's neurologist, and mother). The primary factual dispute at the hearing was whether the lengthy trial return (from July 3 to October 30, 2018) supported the return of daughter to mother's custody. SSA contended the trial return was a failure.

We organize additional evidence around the following questions: (1) What is the evidence concerning mother's participation in her case plan during the reunification period? (2) What is required to administer daughter's anti-seizure medication? (3) What does blood test evidence disclose about the level of medicine in daughter's bloodstream at various times in the reunification period? (4) What other evidence was presented concerning mother's care for daughter's medical needs during the trial return period; and (5) What other evidence, not directly related to daughter's medical condition, can be gleaned from the record to provide context to the question of whether daughter could be safely returned to mother's custody?

1. *Mother's Participation in Her Case Plan and General Efforts to Reunify*

Per its brief in this court, "SSA does not dispute that Mother participated in numerous services arranged by the Agency . . . . [T]his case does not turn on the services in which Mother participated . . . ." The record bears out that mother consistently took part in her assigned services. For instance, in her individual counseling sessions, mother met the goals of the program by verbalizing her role and obligations as a parent with a special needs child. "She readily expressed her feelings of disappointment[ ] in herself" for past failures. In other training, mother "verbalized how to effectively administer medication to her daughter." Mother's "wraparound services" included a parent partner to help mother get organized and obtain transportation to appointments.

Mother loves daughter and expressed her genuine desire to reunify throughout the case. Neutral observers attest to the bond between mother and daughter. Mother maintained visitation when she lost custody of daughter, through multiple placements. There is no evidence mother suffers from substance abuse or mental health problems. There is no suggestion in the record that mother has ever or would ever intentionally harm daughter. Mother has apparently retained custody of her son throughout daughter's dependency case.

In November 2018, mother began unsupervised visits with daughter for 10 hours per week. Daughter had two weekend visits with mother in early 2019. The foster caregiver reported daughter being excited for the visits. Daughter cried when the visits ended.

The foster caregiver was dissatisfied with mother's care during a March 2019 overnight visit. The caregiver suspected mother had not delivered the necessary medication during this visit (mother insisted she had done so). Mother also failed to take daughter to the doctor for an unspecified illness, explaining that the line was too long when she arrived.

But despite this visit, as of April 2019, SSA observed the foster caregiver had "a positive relationship with the mother and [kept] the mother informed of the child's progress and medical appointments. The caregiver ha[d] been instrumental in modeling the child's medication management for the mother." Mother attended all of daughter's medical appointments while daughter was in the custody of the foster caregiver.

Additional training and evaluation occurred to prepare for the trial return of daughter to mother's custody. In April 2019, a social worker visited mother's residence and ensured adequate living conditions existed for daughter.

In May 2019, mother undertook seizure prevention training and received instructions on how to administer Diastat (an anti-seizure medication, used only in emergencies when a lengthy seizure occurs). This training was administered following

the discovery by SSA that Diastat in the possession of the foster caregiver had been administered (the foster caregiver had a used container at her own training and stated her belief that mother had used the medication during a visit). If the use of Diastat is required by a long seizure, 911 should be notified. Mother claimed she was unaware of that. Though not stated expressly in the report or in social worker testimony, it appears SSA may have inferred mother had administered Diastat without calling 911. A week after the training, mother demonstrated her understanding of Diastat administration and her ability to deliver the medication. Mother (and maternal aunt, who helped to care for daughter) took additional seizure prevention and Diastat administration training in August and September 2019.

The reunification period culminated in a scheduled 60-day trial return of custody to mother, extended to last almost four months (July 3 to October 30, 2019).

From September 18 to September 21, 2019 (i.e., in the midst of the trial period), daughter was hospitalized in order to monitor medication levels, based on the neurologist's concerns about fluctuating levels of medication in daughter's bloodstream. Daughter was stable with no seizures during this hospitalization. SSA's September 19, 2019 report recommended that the trial visit continue to allow further assessment of mother's ability to safely care for daughter.

On November 4, 2019, SSA recommended that the court terminate reunification services and set a section 366.26 hearing. The SSA report concluded that daughter's trial visit with mother failed on October 30. Unstable medicine levels during the trial period, as measured by lab tests, was the reason SSA labelled the trial visit a failure. Mother's perceived failure to comply with medicine administration instructions (all doses given at proper times) was SSA's primary safety concern with returning daughter to mother. The key evidence pertaining to these concerns from the trial return period is discussed below.

2. *What is the Proper Dosage and Timing of Administration of the Anti-seizure Medication?*

Though daughter had been prescribed other anti-seizure medications at various times, the primary anti-seizure medication at issue since November 2017 is Felbamate. The purpose of Felbamate is to eliminate or reduce the number and severity of seizures. If too much Felbamate is taken, it can result in poor sleep, irritability, and bad appetite. If too little Felbamate is taken, it can result in more seizures.

The record (mostly statements in the SSA reports) is a tangle of confusion regarding the Felbamate dosages. This confusion is partly caused by the medication being prescribed in both solid pill form (milligrams) and liquid form (milliliters) at various times. The record does not include any information converting the active ingredient in tablet dosages to that in liquid dosages. Regardless, even comparing only the liquid and solid doses to their own kind, there was a huge variation in the prescribed Felbamate dosages during the dependency case.

In January 2018, the dosage was reported to be 4 milliliters, three times per day (12 milliliters total). In April 2018, the dosage was 1500 milligrams daily (pills crushed up in food or drink). In June 2018, the dosage was 600 milligrams, three times per day (1800 milligrams total daily, reportedly an increase). Sometime between June 2018 and April 2019, it appears from the SSA reports that daughter's Felbamate dosage was doubled to 3600 milligrams per day (two 600 milligram tablets, taken three times per day). Daughter's medication was switched back from pill to liquid form at her September 2019 hospitalization. Daughter's Felbamate liquid dose was initially 10 milliliters, three times per day (i.e., 30 milliliters per day). The dose was promptly reduced in late September 2019 to nine milliliters, three times per day. From November 18, 2019 up until the neurologist's testimony in April 2020, daughter's dosage was seven milliliters, three times per day.

The social worker testified that mother was instructed to administer daughter's Felbamate three times per day, at 7:00 a.m., 12:00 p.m., and 5:00 p.m. (though the SSA reports suggest 7:00 p.m. was the actual time designated for the nighttime dosage). In the social worker's view, it was unacceptable to miss these administration times by more than a half an hour in either direction. Consistent administration is required to maintain a steady level of medication throughout the day, including while daughter sleeps. The social worker's source of information was the neurologist who treated daughter and the nurses at Children's Hospital of Orange County.

The treating neurologist confirmed that Felbamate should be administered (in pill or liquid form) three times per day, morning, noon, and night ("typically, before dinner time"). However, the neurologist testified that precision was not necessary, and up to two hours on either side of a specified dosage time would not meaningfully affect blood levels of the medication. Ideally, the medication would be provided at precise eight-hour intervals. But because of the reality of family schedules and insomnia side effects from taking the medication too close to bedtime, medical professionals do not expect such a course to be followed.

3. *Felbamate Levels in Daughter's Bloodstream*

Per the neurologist's testimony, the desired range (in micrograms per milliliter) of Felbamate in an epilepsy patient's bloodstream is "60 to 100," though he noted that "most laboratories list it as 30 to 60. That has been since changed and the American Epilepsy Society lists it as 60 to 100 and some people will tolerate higher as needed." The neurologist occasionally seeks levels as high as 120, and he agreed that a measurement over 120 would be considered toxic "in general." Toxicity is evidenced by side effects, including irritability, decreased appetite, insomnia, and vomiting. From the available record, it does not appear that the word "toxic" in this context equates to

"deadly" (at least at the levels discussed). The neurologist was not aware of any signs of toxicity suffered by daughter.

The neurologist testified that a fluctuation of up to 20 units is normal, and that if the levels are within the 60-100 range and no seizures are occurring he is satisfied. The neurologist agreed that readings between 60 and 120 were not generally a concern, if no seizures were occurring. "If the levels are between 60 and 120 and the child is not having seizures, the usual presumption would be that the medication regimen is being followed."

But the neurologist also stated that large fluctuations are a sign that his instructions are not being followed. One common scenario is that a patient has test results below the target range. The neurologist prescribes a higher dosage based on the low test result, but then the reading will swing too high once the medicine is ingested as directed. The neurologist infers from this scenario that the medicine had not been properly administered under the original, lower-dosage prescription. Another scenario with fluctuating test results involves parents overdosing a child prior to lab tests in an attempt to make up for missed dosages.

The neurologist concluded his testimony with his overall assessment. "[T]here's been a pattern of this since I started taking care of [daughter] and it wasn't just the Felbamate. It was phenobarbital, Topamax, Depakote, and Felbamate. It was four medications that I was consistently taking levels that were fluctuating and many of them were too low and so I have a lack of trust."

One key document in the record is an October 15, 2019 (i.e., toward the end of the trial return and just before SSA's recommendations for the 18-month review) letter from the neurologist to SSA, describing his overall concerns based on his review of daughter's case since the inception of her epilepsy (when daughter was four months old). The neurologist's letter recounted the history set forth above. With regard to the 2019 trial return, the letter cited fluctuating Felbamate readings from July 2019. Despite the

hospital admission in September 2019, the neurologist could not "draw a firm conclusion about the levels and dose administration." Against the neurologist's intended wishes, the nursing staff did not monitor the administration of daughter's medicine during the hospital stay. The letter continued: "Regardless of recent blood levels, . . . I have not been convinced that [mother] has been compliant or that she understands or possibly care[s] about the consequences of her non-compliance. I cannot prove that her non-compliance led to the evolution of [Lennox-Gastaut syndrome] or its difficulty to control, but I do feel this has been a negative factor."

With regard to daughter's Felbamate levels, the neurologist stated during his 18-month review hearing testimony that he was particularly concerned by three results: (1) January 16, 2018—27.9 (reduced from 94 the prior week); (2) February 17, 2018—38.9; and (3) July 20, 2019—36.9 (increasing to 140 the next week). The first two readings predate the initiation of the custodial dependency case (which began following daughter's March 2018 hospitalization).

The following chart includes all Felbamate lab data we were able to find scattered throughout the record. It is unclear whether additional data exists (but is not included in the record), or if all Felbamate testing data is included in the record.

Date	**Custody**	**Felbamate Level**
11/26/17	Mother	30.6
12/4/17	Mother	97
12/11/17	Mother	50
12/18/17	Mother	21.3
1/9/18	Mother	94
1/16/18	Mother	27.9
2/17/18	Mother	38.9

2/24/18	Mother	118.1
3/5/18	Mother	107.8
3/13/18	Mother	32.9
3/23/18	Hospital	53
June 2018	Orangewood	77
7/13/19	Mother	100.7
7/20/19	Mother	36.9
7/27/19	Mother	140.5
7/31/19	Mother	107.9
8/7/19	Mother	110.9
8/14/19	Mother	87.4
8/21/19	Mother	86.8
8/28/19	Mother	91.7
9/4/19	Mother	131
9/11/19	Mother	146
9/18/19	Hospital	122
9/19/19	Hospital	129.4
9/20/19	Hospital	93
9/21/19	Hospital	131.4
9/25/19	Mother	136
10/5/19	Mother	129
10/17/19	Mother	104
10/25/19	Mother	120
11/8/19	Orangewood	133
12/16/19	Orangewood	144
2/27/20	Foster Home	80

The only low reading that occurred during the trial return was July 20, 2019 (the 36.9 reading). Regarding that result, the neurologist conceded it could have been lab error (that "would have been one of the possibilities for an explanation"). "Lab error is where a specimen is drawn and through either the specimen being altered, the equipment, human error or other factors, the result comes out to something that would not be expected."

The July 29, 2019 SSA report raised this July 20 reading as a concern, but the trial visit did not end at that time. Per the report, the neurologist's "office stated it could be a lab error and [they] will review the child's weekly lab for July 27, 2019. [Mother] assured [SSA that daughter] was taking the medication as prescribed. The mother stated she would send [SSA] videos of [daughter] taking the medication daily."

Felbamate's half-life (i.e., "the reduction of medication by half in a given period of time") is approximately eight hours. According to the neurologist, this particular result (i.e., a huge reduction to 36.9 as compared to the previous and following weeks) could not have been solely the outcome of a "peak" or "trough" reading. A peak reading occurs when the blood test is administered immediately after a dose is administered and absorbed. A trough reading occurs when the blood test is administered just before a dosage is administered ("it is meant to be the lowest amount of medication in the system prior to the next dosing"). The neurologist wants to obtain a trough reading of Felbamate blood testing. The neurologist was unable to opine as to what an appropriate peak reading would be, as he does not try to obtain peak readings.

SSA's September 3, 2019 report provided additional information about the July testing: "On July 30, 2019, [the lab] did not draw blood . . . because the mother had reported she gave [daughter] the medication before coming in to get labs. On July 27, 2019, the . . . level was 140.5 and the mother reported she gave the child the medication before the lab test because the week prior the mother did not give her the medication before the lab test and the . . . level had significantly dropped."

In other words, mother inferred (or at least claimed that she had inferred) that the problem on July 20 was that the test was based on a trough reading and tried to avoid that the next week by providing daughter's morning dose prior to the weekly lab test rather than after the weekly lab test. Though it is unclear what the foundation for the social worker's knowledge was (e.g., based on mother's statements or based on medical records), the social worker testified that the blood tests were generally performed between 6:00 a.m. and 7:00 a.m., other than two occasions when mother claimed the lines were long at the lab. Perhaps casting some doubt on the idea that tests occurred at 6:30 a.m., mother reported to SSA in 2018 that it took her an hour and a half by bus to reach the lab site.

SSA also reported an August 2019 conversation with the neurologist's nurse, in which the nurse suggested that the 87.4 reading on August 14, 2019 could be a sign daughter was not receiving her full dose, based on the large decline from the previous week (110.9).

In November 2019, a SSA report cited the instability of daughter's Felbamate levels as the reason for the failure of the trial return. In her testimony, the social worker agreed there were no additional test results (other than the results noted above in the chart) available for the late 2019 and early 2020 period of time. When asked about the large difference between the reading in December 2019 (144) and February 2020 (80), which were both occasions when daughter was not in mother's testimony, the social worker indicated the drop was not concerning because the 144 level was "toxic." The social worker had no recollection of whether there was concern about the fluctuation that occurred during the September 2019 hospital stay.

The neurologist, asked about the December 2019 result of 144, testified he would be concerned in this situation that the dosage was too high, that lab error occurred, or that this was a peak level reading (rather than the desired trough reading). The

neurologist would be less concerned by high readings if he knew that they were peak readings.

Records from several days in December 2019 at Orangewood show that daughter's Felbamate was administered at times varying from the times indicated by the social worker. For instance, morning dosages were delivered at 8:40 a.m., 9:56 a.m., and 10:21 a.m. As the chart above demonstrates, Felbamate levels fluctuated when daughter was outside of mother's custody.

4. *Other Evidence Bearing on Mother's Capability to Meet Daughter's Medical Needs*

Mother briefly testified, answering six questions on direct examination; no cross-examination occurred. During the trial return of daughter to her custody, mother was in charge of administering Felbamate. She administered the medication three times per day. Mother claimed she kept to a fixed schedule every day during the trial return. The medication was administered in pill form at first, then in liquid form. In the liquid form, daughter spit out the medication on two occasions.

The social worker testified about mother's record keeping. The social worker asked mother to maintain a log book with the time and date of each dose of medication, and asked Mother to text and send a video of her giving the dose and daughter swallowing the medication. Mother did not regularly send a phone message after each delivery of medication, despite being instructed to do so. After July, mother texted, or sent a photo or video to social worker, around 9 to 12 times a week. Mother made entries in the log book "about four times per week" (rather than 21 times per week) and there were weeks where she did not log anything. The social worker believed Mother was unable to adhere to daughter's medication schedule because oftentimes weeks would be missing from the log. Mother sometimes forgot to make entries contemporaneously and would back date entries.

The actual log or logs prepared by mother are not included in the record. Nor are records of messages received from mother documenting delivery of medicine. Nor are copies of contemporaneous logs maintained by SSA tracking mother's compliance (or lack thereof with daily reporting requirements). SSA's review of mother's October 2019 log "indicated [daughter] received her Felbamate medication at around 7 a.m., 12 p.m., 7 p.m. every day." Mother's alerts were set for 6:55 a.m., 11:40 a.m., 6:55 p.m.

5. *Other Evidence Potentially Bearing on the Court's Ruling*

Though not explicitly relied on by the court in its ruling, the record includes evidence pertaining to issues peripheral to daughter's medical care that we mention here for the sake of completion. In May 2019, mother was incarcerated for unspecified reasons. In March 2020, mother had an outstanding bench warrant for failure to appear at a criminal proceeding for driving without a valid license.

At a January 2020 scheduled visitation at Orangewood, a social worker noticed an open container of beer in mother's vehicle. Mother attributed the beer to father, and claimed she had not noticed it. Father confirmed mother's version of events.

In March 2020, father battered mother at his residence. Father punched mother in the face and hit her head against a table. Mother called the police and father fled. Father did not participate in his case plan, did not request visitation with daughter, pleaded guilty to numerous criminal property offenses in November 2019, and had substance abuse issues.

There was an April 2020 virtual neurology appointment that mother was not permitted to attend. SSA's expectation was that mother would phone to inquire about the results, but she failed to do so at the appointed time.

Court's Ruling at 18-month Review

The court found reasonable reunification services had been provided. The court's ruling focused mostly on the question presented here, whether daughter could safely be returned to mother. "The extent of progress which has been made toward alleviating or mitigating the causes necessitating placement by the mother has been moderate." But the court ruled that returning daughter to mother would place daughter's physical well-being in a substantial risk of danger, due to mother's failure adequately to grasp and implement healthcare directives necessitated by minor's condition.

"With regard to mother, the issue is not so much what [daughter's] levels were at times that she was out of the mother's care, whether that's at Orangewood or in the hospital . . . . It might be that her levels are extremely difficult to control and are outside norms. [¶] It doesn't answer the question, however, as to whether or not mother can safely administer and track [daughter's] medication and her health care needs. None of this answers the question as to why mother didn't log every medication administration when she was requested to do so by the social worker. If we had documentation that mother did everything correctly, she made all the appointments, that she gave [daughter] all the medication when she was supposed to at the right times and got tested at the right times and [daughter] still tested positive, that would be one thing. That's not what we have."

Daughter is "not safe with somebody who forgets. . . . Whether she has an easy case or an extremely difficult case, she is not safe with a parent who forgets to log when she's giving medication, forgets to inquire about an appointment. She's just not safe."

"Mother just has not, in the two years [daughter] has been in the dependency court, shown with any level of consistency that she can safely administer [daughter's] medication and stay on top of her medical requirements. That's the problem."

The court terminated reunification services and set a section 366.26 hearing for August 19, 2020.

DISCUSSION

Standard of Review

"'Family preservation . . . is the first priority when child dependency proceedings are commenced.'" (*In re Precious J.* (1996) 42 Cal.App.4th 1463, 1472.) This primary goal of dependency proceedings persists until reunification services have terminated and the matter is set for permanency planning at a section 366.26 hearing. (*Patricia W. v. Superior Court* (2016) 244 Cal.App.4th 397, 420.) Only when reunification services are terminated does "the focus shift[ ] to the needs of the child for permanency and stability." (*In re Marilyn H.* (1993) 5 Cal.4th 295, 309.)

At the 18-month review hearing, the court must reunify the dependent child with her family unless it finds by a preponderance of the evidence "that the return of the child to his or her parent or legal guardian would create a substantial risk of detriment to the safety, protection, or physical or emotional well-being of the child." (§ 366.22, subd. (a)(1).) SSA bears the burden of proof. (*In re Marilyn H.*, *supra*, 5 Ca1.4th at p. 308.) It is a "fairly high" standard and does not mean the parent in question is imperfect or less able than a potential replacement. (*David B. v. Superior Court* (2004) 123 Ca1.App.4th 768, 789.) "When we are considering whether to deprive a parent of custody, we are concerned only about their grasp of the important parenting concepts — things such as a child's need for security, adequate nutrition and shelter, freedom from violence, proper sanitation, healthcare, and education." (*Id.* at p. 790.)

We review the court's findings for substantial evidence. (*In re Zacharia D.* (1993) 6 Cal.4th 435, 456.) "[W]e indulge all inferences in favor of the factual conclusions reached by the trial court." (*David B. v. Superior Court*, *supra*, 123

Cal.App.4th at p. 794.) But "the standard is not satisfied simply by pointing to '"isolated evidence torn from the context of the whole record."'" (*In re I. C.* (2018) 4 Cal.5th 869, 892.)

Application of Substantial Evidence Standard to the Court's Order

It is uncontested that this dependency action was justified when it began as a noncustodial case in March 2017. It is uncontested that the removal of daughter from the custody of mother in May 2018 was also justified, and that the return of daughter to mother's custody was not required at the six-month or 12-month review hearings. Indeed, it might be posited (with the benefit of hindsight) that SSA should have acted sooner to protect daughter with a custodial dependency case or more aggressive noncustodial services. Father's negligence appears to have caused daughter's medical condition. Thereafter, mother's neglect in administering medicine and failure promptly to seek medical care for daughter allowed daughter's condition to worsen. Mother's continued failure to administer medicine consistently or seek medical assistance promptly led to the custodial phase of this case. Reasonable concerns about the safety of daughter in mother's custody led to the extension of this dependency case to the 18-month review. No appellate challenge was raised to any of the trial court's actions until this order.

The question in this writ proceeding is whether substantial evidence supports the court's finding that a substantial danger to daughter's physical health still exists if daughter were to be returned to mother's custody, now that daughter is five years old and mother has taken part in the reunification plan prescribed by SSA and ordered by the court. One specific risk of harm to daughter is mother's alleged inability to administer consistently the correct dosage of seizure medication at the correct times. More generally, the risk of harm to daughter is that her medical needs require a parent who is capable of paying close attention every single day to administration of medicine, medical appointments, and physical signs that medical intervention is required.

For the most part, factors other than mother's ability to adequately provide health care for daughter support the return of daughter to mother. Mother expended a great deal of effort engaging with her case plan. She avoided many of the common pitfalls of parents that permanently lose custody of their children (e.g., substance abuse). Mother conceded she had provided insufficient care for her daughter and sought to fix the problem. There is a clear bond between mother and daughter which mother maintained throughout the dependency case (and, though not technically relevant to the issue before us, there is no caregiver identified in the record that is an obvious alternative to provide love and a permanent home to daughter). Mother improved her parenting knowledge and abilities during the dependency, and her continued maturation into adulthood is also a factor suggesting her care for daughter will improve. There is a reason this dependency case (including both the family maintenance phase and reunification phase) lasted more than three years before coming to a head. It is obvious that neither SSA nor the juvenile court were eager to separate daughter from mother (though both ultimately concluded it was necessary to do so).

The court's order recognized that "moderate" progress had been made by mother during the dependency case. SSA authorized a lengthy trial period of return to mother between the 12-month and 18-month review hearings, eventually extending a contemplated 60-day trial return to nearly four months (from July 3 to October 30, 2019). There is no evidence suggesting daughter's condition worsened or that she suffered from any new health problems as a result of the trial return.

Daughter's care was a challenge for anyone. SSA was unable to find foster caregivers for daughter at several points in time because of the difficulty of managing her medical issues. SSA even noted a misstep by the foster caregivers who served from June 2019 to May 2020 (i.e., the inadequate supply of Diastat on hand).

The court's ruling recognized that fluctuations in Felbamate levels, on their own, do not demonstrate that mother is incapable of caring for daughter. We agree. The

petition successfully points out there is not much difference in levels or fluctuation when comparing daughter's tests while in mother's custody during the trial return to tests while daughter was in others' custody. Given the varying dosages provided to daughter and the lack of clear answers from the neurologist's expert testimony, it is difficult to say whether daughter had the correct dosage during the trial return. It is impossible to say based on the record provided what the precise target blood level of Felbamate was for daughter (the gist of the expert testimony is that it could be anywhere between 60 and 120). Daughter's Felbamate level appears to be slightly too high during the trial return. But there is insufficient evidence to conclude that the high levels resulted from mother's failure to properly medicate daughter, as high levels occurred when daughter was not in mother's custody. Daughter's Felbamate levels during the trial return were certainly much better than those recorded in late 2017 and early 2018, which instigated the custodial portion of the case because it appeared daughter was not receiving her medication. There is no evidence linking any of the high readings or fluctuations in 2019 to adverse health outcomes for daughter.

The most concerning test result during the trial return was the low, July 20, 2019 reading (36.9). It is possible, and consistent with her pre-2019 history, that mother neglected her duties in the second week of the trial period, leading to this unacceptably low reading. It is also possible the low July 2019 reading occurred as a result of "lab error" as conceded by the neurologist. Further, the evidence pertaining to the effect of peak and trough levels appears to be in tension with the evidence concerning the proper time of day for medicine administration. There is no specific evidence in the record as to when the last dose was administered on July 19, and when the blood draw occurred on July 20. For instance, assume Mother (properly) gave daughter her nightly dose at 5:00 p.m. the night before the test and (properly) withheld the morning dose before the blood test. Then, if the blood was taken at 9:00 a.m., that would have been 16 hours (not eight

hours) between the previous dose and the blood draw.[3] The neurologist's testimony indicated a trough reading after approximately eight hours was desirable. There was a failure of proof (recall that SSA had the burden of proof) regarding the precise meaning of the July 20 Felbamate test result to allow us to credit it alone as substantial evidence supporting the court's order.

Thus, isolated from the broader context of this case, neither the Felbamate blood test results nor suggestions that mother was not fastidiously punctual with regard to every delivery of medication (i.e., provided exactly at the appointed times) support the court's ruling. In light of the history of this case, both the low July 20, 2019 Felbamate reading and the fluctuations in levels through the trial period are concerning. But the method of gathering and presenting this quantitative evidence from the trial return lacks sufficient scientific rigor to support the drawing of any firm conclusions against mother.[4] The trial court's ruling appears to be in accord with this analysis.

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[3] Recall the half-life of Felbamate is eight hours, which, if we understand the neurologist's testimony accurately, would have meant a 75 percent reduction in medication level over a period of 16 hours.

[4] What might appropriate rigor look like? Recognizing the limits of our knowledge regarding the feasibility of the following suggestions, a better test of mother during the course of the dependency case could have included: (1) regular consultations by SSA with daughter's neurologist to determine the current prescription dosages and desired range of medication(s) levels in daughter's blood based on trough readings, with a contemporaneous log of this information maintained by SSA and regularly presented to the court; (2) creation of a realistic plan (taking into account the location of daughter's residence and the lab, and the lab's hours of operation) to facilitate the drawing of daughter's blood at a trough period approximately eight hours after the last previous administration of medication; (3) regular blood testing, with drug levels and times of drawing blood reported to SSA and then submitted regularly to the court by SSA in the form of a comprehensive log maintained by SSA; (4) required thrice-daily submission (via phone text message, preferably with video) by mother to SSA of proof of prescription drug administration and the times of such administration, with a comprehensive log of these submissions maintained by SSA and copies of the log submitted to the court regularly; and (5) regular SSA communications with medical providers to ensure attendance at appointments, with a complete log of all such

The trial court pointed to the entire context of the case as supporting its ruling, not the Felbamate blood testing in isolation. Consistent administration of medication every day is essential to daughter's physical health. Deficiencies in monitoring daughter's health throughout her life can be fairly attributed to mother's negligence, including maladministration of medication. Mother failed to regularly administer medicine in 2017 and 2018, leading to the custodial phase of this dependency case. The neurologist, understandably, opined he did not trust mother based on the entire history of the case. One possibility regarding the low reading in July was that mother missed dosages that week during the trial period. Then, the next week, mother decided (apparently on her own initiative) to dose daughter prior to the lab tests to fix the problem (though she did not try to hide this decision, which led to its immediate discovery). Perhaps the high readings at other times during the trial period suggest mother was not following instructions to obtain the lab test prior to administering the morning dosage.

The social worker's testimony also indicates mother could not keep up with paperwork and reporting duties designed to confirm she was administering medicine three times per day, at appropriate times of day. This testimony, if credited, arguably supports a conclusion that mother lacks the sustained diligence and discipline that daughter's health requires. We note, however, that SSA did not bring forth documentary evidence showing the specific lack of compliance in this area. The contemporaneous SSA reports do not detail problems with mother's recordkeeping, but rather offer conclusory assertions that mother did not keep up with her duties. And mother was not specifically and contemporaneously warned that her incomplete record keeping was going to cause the trial return to fail. Instead, it appears that SSA decided that the trial

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appointments maintained by SSA and submitted to the court regularly. Presumably, there would also need to be prompt consequences and corrective action for deviations from this program by mother, to ensure both the safety of daughter and the integrity of the blood test data.

return had failed based on the fluctuating levels of Felbamate and the neurologist's letter, then cited the lack of complete recordkeeping to buttress that conclusion.

Mother also faced some criminal law and potential immigration issues, but those were not relied on by the court as a barrier to reunification. Likewise, recent domestic violence perpetrated by father against mother raises another potential concern for the safety of daughter, but that issue was not relied on by the court as a barrier to reunification of daughter *with mother*. Several trivial events (like mother failing to promptly call the social worker to discuss an appointment mother was not allowed to attend) are also pointed to by SSA as indicative of a larger problem, but these are hardly the stuff of deeming a parent unfit for reunification.

This is a difficult case. The court's ruling is superficially reasonable. Left to her own devices, the history of this case suggests mother (despite her professed and sincere good intentions) cannot be trusted to provide consistent care for daughter. Daughter's health problems could have been avoided (had parents, and in particular father, been better informed about the dangers of improper sleeping conditions for infants) and mitigated (had mother consistently followed the instructions of daughter's health care providers). The neurologist distrusted mother based mostly on pre-2019 conduct and interpreted the trial return results within that framework of mistrust. SSA, which for most of daughter's life gave mother the benefit of the doubt, appeared to follow the neurologist's lead after he sent his October 2019 letter expressing his overall character judgment of mother. The court, acknowledging that mother punched some holes in SSA's case regarding the trial return, agreed that the return of daughter to mother would endanger her physical safety.

In our view, the sad history of the case and mother's past failings do not mean that daughter cannot safely be returned to mother at this point in time. Mother's education, improvement, and maturation demonstrate that daughter would not be returning to the same parent who failed her. And as daughter ages (she is now five), it

may be easier to administer medicine to her and easier for SSA and other societal caregivers (e.g., schools) to monitor her safety. In our view, the evidence available in the record can only support a conclusion that the trial return was *mostly* a success. The blood testing showed that mother was administering daughter's medication as well as anyone else. There is insufficient evidence to support SSA's labeling of the trial return as a failure.

Under the circumstances presented here (i.e., a basically fit parent who struggles with caring for a child with special medical needs), the correct analytical framework is not whether it would be safe to return daughter to mother without any further involvement of SSA or the court. The petition notes that returning daughter to mother "would not have closed the case. Rather, it would initiate a period of Family Maintenance wherein the court and counsel would be able to continue monitoring [daughter's] medication while in Mother's care." Indeed, though this does not occur automatically, juvenile courts have discretion to continue family maintenance services beyond the 18-month review hearing if the dependent child is returned to the custody of the parent. (*Bridget A. v. Superior Court* (2007) 148 Cal.App.4th 285, 312.)

We conclude that, viewed from the perspective appropriate to this case, the court's ruling lacks substantial evidence. There is insufficient evidence in our record to support a conclusion that there is currently a substantial danger of physical harm to daughter, if she is returned to mother's custody with checks in place to verify that mother is administering medication to daughter and transporting daughter to medical appointments. We agree there is substantial evidence that mother cannot be trusted to care for daughter on her own. We disagree there is substantial evidence that daughter will suffer physical harm if she is returned to mother's custody with appropriate monitoring in place to assist her in maintaining the necessary discipline and hard work of caring for daughter.

DISPOSITION

The petition for an extraordinary writ is granted. Let a peremptory writ of mandate issue directing the juvenile court to: (1) vacate its order terminating reunification services and scheduling a section 366.26 hearing; and (2) set a continued 18-month review hearing.

The continued 18-month review hearing may include the introduction of additional evidence by any party bearing on the safety of returning daughter to mother's custody, including evidence related to events that have transpired since April 2020 and additional evidence providing further understanding of events that occurred prior to April 2020. The analysis of whether daughter may be safely returned to mother's custody at the time of the continued 18-month review hearing shall include consideration of any prospective safeguards that would be in place as part of a family maintenance plan to protect daughter from harm.

IKOLA, J.

WE CONCUR:

ARONSON, ACTING P. J.

GOETHALS, J.