**MAY CONTAIN INFORMATION PROTECTED BY ORDER OR STATUTE**

**REDACTED**

# SUPREME COURT

OF THE

# STATE OF CONNECTICUT

---

## S.C. 19426

**IN RE: CASSANDRA C.**

---

**BRIEF OF PETITIONER-APPELLEE**
**WITH ATTACHED APPENDIX**

---


*FOR THE PETITIONER-APPELLEE:*

GEORGE JEPSEN
ATTORNEY GENERAL OF CONNECTICUT

BENJAMIN ZIVYON
MICHAEL BESSO
ROSEMARIE WEBER
ASSISTANT ATTORNEYS GENERAL

JOHN E. TUCKER
ASSISTANT ATTORNEY GENERAL
OFFICE OF THE ATTORNEY GENERAL
MACKENZIE HALL
110 SHERMAN STREET
HARTFORD, CT 06105

*TO BE ARGUED BY:*

JOHN E. TUCKER
ASSISTANT ATTORNEY GENERAL
TEL. (860) 808-5480
FAX (860) 808-5595
EMAIL: John.Tucker@ct.gov

## TABLE OF CONTENTS

Page

Page

## COUNTER-STATEMENT OF ISSUES

I. Did the trial court's order appointing DCF as medical decision maker for Cassandra, a 17 year old girl, to enable the child to get life-saving treatment for her otherwise fatal illness constitute a constitutional violation of her rights such that the alleged violation "clearly exists and clearly deprived" her of a fair trial under *State* v. *Golding*, 213 Conn. 233, 239-240 (1989)?

II. Should this Court recognize the common law mature child exception when:

a. In the absence of facts that could give rise to the mature child exception this Court would be issuing an advisory opinion?

b. The exception was not raised before or during the hearing below, and the trial court found that the child was not capable of making mature decisions on her own behalf?

III. Did the trial court violate the child's right to procedural due process under the circumstances of the case, given the urgency of the matter, by failing to, *sua sponte*, order a psychological or psychiatric evaluation to determine whether the child was mature for purposes of the mature child doctrine, where that doctrine was not raised before or during the hearing below, the child and mother did not ask for a psychological or psychiatric evaluation, and where the child and mother must demonstrate that the alleged violation "clearly exists and clearly deprived" her of a fair trial under *State* v. *Golding*, 213 Conn. 233, 239-240 (1989)?

## TABLE OF AUTHORITIES

**Case** **Page**

**Case** **Page**

**Case** **Page**



Connecticut Authority



Other Authority

Treatises Page

## NATURE OF THE PROCEEDINGS

This case concerns a 17 year old girl diagnosed with cancer. The respondent mother failed to obtain life-saving treatment for her child, Cassandra. On October 30, 2014, the court (*Westbrook, J.*) granted an *ex parte* order of temporary custody (OTC), finding that Cassandra was in immediate risk of physical harm from her surroundings. A contested hearing took place on November 12, 2014. The trial court (*Taylor, J.*) sustained the OTC, and issued orders directing that Cassandra promptly receive medical treatment to treat her cancer. Thereafter, after two days of medical treatment, Cassandra ran away from home. On December 9, 2014, a further hearing was held before the trial court (*Quinn, J.*), after which the court appointed the Department of Children and Families (DCF) as medical decision maker for the child.

On December 17, 2014, the respondent mother and child filed a joint motion to enjoin DCF from requiring Cassandra to undergo further medical treatment. Following oral argument, the court (*Taylor, J.*) denied the joint motion. The respondent mother and child filed a joint motion for emergency exercise of supervisory powers, which the Supreme Court treated as a motion for review of the denial of an emergency motion for stay. On the evening of December 17, 2014, this Court issued an order leaving the trial court order in effect, and directed DCF to file a response to the joint motion no later than 10:00 a.m. on December 18, 2014. DCF timely filed a responsive memorandum, transcripts of the proceedings before Judge Taylor and Judge Quinn and the affidavits in support of the OTC.

On December 18, 2014, the Supreme Court granted the motion for review, but denied the requested relief thereby leaving the superior court orders in place. On that same date, the joint movants applied for certification to the Chief Justice to take an

interlocutory appeal and filed an appeal of the trial court's decision. On December 19, 2014, the Supreme Court denied the application for certification, allowing the movants to proceed on the appeal that they had already filed. The Supreme Court issued an expedited briefing schedule. In response to the appeal papers making a claim that Cassandra was a "mature child", a claim that was not raised below, DCF moved for expedited articulation of Judge Quinn's decision. The appellants filed an objection. On December 24, 2014, Judge Quinn issued an articulation of her decision. (App. A7-A11.)

## COUNTER-STATEMENT OF FACTS

The evidence at the two hearings reveals the following facts.

### A. Facts Relating To Respondent's Mother's Failure To Obtain Life Saving Medical Treatment For Child's Cancer.

Cassandra was 16 years old when she developed a mass on the right side of her neck. (Transcript (Tr.) 11/12/2014, p. 50.) Initially, her pediatrician, Dr. Hemant K. Panchal, referred Cassandra to the infectious disease department at Connecticut Children's Medical Center (CCMC) to determine the cause of the mass. (*Id.*) Cassandra began treatment with an infectious disease specialist, Dr. Henry M. Feder, at CCMC on July 1, 2014. (Tr. 11/12/2014, p. 52.) Dr. Feder attempted to follow up with Cassandra and her mother by scheduling an appointment two weeks later. (*Id.*) Mother did not bring Cassandra in for that appointment. (*Id.*) Another appointment was made with Mother but still she failed to bring Cassandra for the appointment. (*Id.* at 53.) Finally, in early August, 2014, Mother brought Cassandra in for a follow up appointment. Dr. Feder conducted a chest x-ray which revealed that Cassandra's lymph nodes were clearly enlarged. (*Id.* at 54.) "So it made it clear that this was potentially a lymphoma or a cancer." (*Id.* at 54.) Dr.

Feder grew concerned that Mother was not attending to Cassandra's medical needs in a timely basis. (*Id.* at 52, 54.)

Thereafter, Dr. Feder scheduled a needle biopsy and Mother missed the appointment. (*Id.* at 55.) "[W]e needed tissue, and the first chance to get the tissue when it was all planned and set which took a week was missed. *And that distressed me.*" (*Id.*) (emphasis added). Although Dr. Feder ensured that a second appointment was scheduled and that the needle biopsy was conducted, Mother stopped the procedure while it was in progress. (*Id.*) Nevertheless, the results of the partially completed needle biopsy were not definitive for thyroid cancer but revealed that Cassandra suffered from some sort of lymphoma concerning the mass in her neck. (*Id.* at 57.) CCMC wanted to conduct a PET scan to determine the nature and extent of the tumor in Cassandra's neck, however, Mother refused. (*Id.* at 57.) Dr. Feder's concern grew when it was clear that Mother was not following up with medical providers regarding the necessary testing to confirm a cancer diagnosis. (*Id.* at 55, 58-59). As a result, on October 2, 2014, Dr. Feder, fearing for the child's health, made a referral to DCF. (*Id.* at 58-59.)

Eventually, Cassandra returned to CCMC for an incisional biopsy on September 12, 2014. (Tr. 11/12/2014, p. 72.) The surgeon, Dr. Brendan Campbell, met with mother and Cassandra days prior to the surgery as well as the day of the surgery to review the procedure and answer questions. (*Id.* at 75.) After Dr. Campbell removed a small portion of tissue from the mass on Cassandra's neck, a pathologist who was present during the procedure performed the preliminary analysis, which revealed the diagnosis of Hodgkin's Lymphoma. (*Id.* at 76.) Pathology conducted additional testing confirming the diagnosis. (*Id.* at 78-79.) Shortly after the biopsy was performed, Dr. Campbell informed mother of the

results. Dr. Campbell raised concerns regarding Mother's reaction to the diagnosis. (*Id.* at 80.)

> [T]here was a lot of criticism on the mother's behalf and a lot of questions which were really unusual about what our diagnosis was, about the tissue possibly not having been Cassandra's, and not – and a lot of issues – she was very upset that I had not removed the entire lymph node. . . .
> And there were real concern on behalf of both Dr. Hank Feder, and Dr. Mike Isakoff, Dr. Eileen Gillan, and myself that Cassandra's mother was not coming in and getting the appropriate medical – the startup of the appropriate care for this disease, malignant disease which is lethal if it's untreated.

(Tr. 11/12/2014, p. 80.)

There was no question in Dr. Campbell's mind that the child had Hodgkin's Lymphoma. (Tr. 11/12/2014 p. 87.) Dr. Campbell also indicated that CCMC offered to facilitate a second opinion in Boston, at Yale, and in New York City. (*Id.* at 80.) Mother, however, refused, stating that she would set it up on her own. (*Id.*) Dr. Campbell explained:

> [T]hat's very concerning from a clinician's perspective because when a disease requires timely treatment and it's something like Hodgkin's Disease, it's not just a question of showing up and getting a second opinion. The person who is providing that second opinion needs to have access to the tissue, needs to have access to the imaging studies, needs a lot of information that we can very easily provide them . . . .

(Tr. 11/12/2014 at 81-82.)

> So one of the reasons we like to help arrange these second opinions is we can talk to the right person at another institution . . . For example, Dr. Isakoff is – you know, knows the oncologist at Boston Children's Hospital very well. He can call someone who is a, you know, nationally – internationally recognized expert on Hodgkin's Disease or, you know, cancers that involve the lymphatic system and talk to that person and get them in more quickly... A lot of times if you were to just call out of the blue and say, hey, and I want to be seen for a second opinion, you're not going to be able to arrange for that type of follow up or that type of second opinion as expeditiously.

(Tr. 11/12/2014 at 85-86.)

Following the September 12, 2014 diagnosis, CCMC attempted to schedule a PET scan for Cassandra as well as other meetings to discuss her diagnosis; however Mother canceled the appointments. (Tr. 11/12/2014 at 106.) In fact, Dr. Isakoff's partner, Dr. Gillan, called mother to discuss Cassandra's diagnosis with her, and attempted to schedule an appointment on at least two occasions, but Mother refused to come in for an appointment. (*Id.* at 116.) As a result, Cassandra did not receive treatment for her Hodgkin's Lymphoma, nor was she seen by another physician until almost one month later.

On October 7, 2014, Mother met with Dr. Michael Isakoff, a pediatric oncologist at CCMC, board certified in pediatric hematology and oncology, to review the diagnosis, and what treatment was recommended. (*Id.* at 105.) Dr. Isakoff is the medical director for the Division of Hematology and Oncology at CCMC. (Tr. 12/9/2014 at 4; App. A50.) First, Dr. Isakoff was concerned that mother did not bring Cassandra to the meeting. (*Id.* at 117.) Dr. Isakoff indicated that it was his understanding that Cassandra would accompany her mother to the meeting, "which is what our typical would be especially given a 17 year old with the diagnosis." (*Id.* at 117.) During his meeting, Dr. Isakoff attempted to review Cassandra's diagnosis and his recommendation for treatment. (*Id.* at 113-14.) Dr. Isakoff observed that Mother was hostile and wanted to complain about the process by which she was informed about the diagnosis rather than discuss the diagnosis itself. (*Id.* at 114.) Nevertheless, Dr. Isakoff focused his discussion on Cassandra's diagnosis and the need to start treatment within two weeks. (*Id.* at 114.) Mother questioned the diagnosis. (*Id.* at 118.) Dr. Isakoff explained the process by which a second opinion could occur. (*Id.* at 119-20.) Dr. Isakoff explained Cassandra's need for timely treatment, the high probability of cure, and his concern that a month had passed without treatment. (*Id.* at 111 – 114.)

Eventually, Mother sought a second opinion from Dr. Matthew Richardson, a pediatric oncologist at Baystate Hospital in Springfield, Massachusetts, on October 14, 2014. (Tr. 11/12/2014 at 120.) Dr. Richardson reviewed Cassandra's records and confirmed the diagnosis. (*Id.*) Both Dr. Isakoff and Dr. Richardson agreed that the challenge would be to help Mother accept the diagnosis and understand that Cassandra would die if she did not receive treatment. (*Id.*) Dr. Richardson attempted unsuccessfully to schedule additional medical appointments with Mother. (*Id.* at 126.) Mother indicated that she was upset with Dr. Richardson because he communicated with Dr. Isakoff regarding the diagnosis. "That's not a second opinion to me . . . [t]hat's agreeing with the first opinion." (*Id.* at 191.) Ultimately, Mother informed Dr. Richardson that Cassandra was going to receive treatment elsewhere. At that point, Dr. Richardson called DCF to express his concerns. (*Id.* at 15.)

DCF received the initial referral from Dr. Feder on October 2, 2014 and commenced its investigation the next day. (Tr. 11/12/2014 at 11.) DCF reached out to Dr. Feder as well as to Mother and Cassandra to assess the situation. (*Id.*) Mother indicated that she was in the process of obtaining a second opinion and did not want to speak with DCF or have any contact with DCF. (*Id.*) Investigative Social Worker Margaret Nardelli attempted to follow up with Mother regarding Cassandra's medical treatment but was unsuccessful. (*Id.* at 14.) At one point, DCF conducted an unannounced visit and left a note for Mother because no one was home. (*Id.* at 14.)

Since the beginning of the investigation, DCF also received a referral from Dr. Panchal, Cassandra's pediatrician, as well as Dr. Richardson from Baystate Hospital. (Tr. 11/12/2014 at 16-17.) As a result of these concerns and mother's failure to obtain

necessary medical treatment for Cassandra, DCF sought and obtained an *ex parte* order of temporary custody (OTC) on October 31, 2014. (*Id.* at 21.) Thereafter, a contested hearing was held on November 12, 2014, during which Cassandra testified that she would obtain treatment if she could go home.

Q: So will you go through chemotherapy?
A: If I can go home.
Q: And if you don't get to go home today?
A: Then I'm not doing it.

(Tr. 11/12/2014 at 177 – 181; App. A46.)

Similarly, Mother testified that she supported her daughter's decision to have chemotherapy and will do everything in her power to ensure that Cassandra receives treatment. (Tr. 11/12/2014 at 191.) Mother explained that she had health insurance, her employment was flexible because she was self-employed, and she would ensure Cassandra attended all her appointments. (*Id.* at 194.)

Ultimately, the court (*Taylor, J.*) sustained the OTC in a written decision dated November 14, 2014. (App. A1-A6.) The court vested custody in the Department but ordered that she be placed in her home subject to a number of conditions; one of which being that she undergo treatment for her cancer.

On November 17, 2014, Cassandra underwent her first chemotherapy treatment. (Tr. 12/9/2014, p. 32.) On November 18, 2014, DCF Social Worker Nardelli transported Cassandra to her medical appointment, and stayed with her while she underwent her second chemotherapy appointment. (*Id.* at 33.) Mother elected not to attend. (*Id.*) At that second appointment, Cassandra was informed that she would need a port inserted to administer chemotherapy because the veins that were being used to administer the chemotherapy were compromised. (*Id.* at 33-34.) The procedure to insert the port was

scheduled for early the following morning. (*Id.* at 35.) Mother indicated that she would not attend that appointment. (*Id.* at 35.)

Cassandra missed that appointment because, sometime during the night of November 18, 2014, Cassandra left her home. (Tr. 12/9/2014 at 35-36.) When DCF arrived to transport Cassandra to her chemotherapy appointment at 4:05 a.m. on November 19, 2014, Cassandra was not present. (*Id.* at 35.) Mother refused to contact police and made no effort to assist in locating Cassandra. (*Id.* at 36.) Mother did not contact DCF following the disappearance of her daughter nor did she request that a "silver alert" be issued." (*Id.*) Mother did not contact any of Cassandra's friends to determine Cassandra's whereabouts. (*Id.*) DCF requested that Mother contact the Department if Cassandra returned home. Mother replied that her daughter would not be coming home. (*Id.*) Approximately one week later, Cassandra made contact with the Department, through her attorney, expressing her intention to return home. (*Id.* at 37.) Cassandra returned home on or about Monday, November 24, 2014. (*Id.*)

Thereafter, the Department facilitated a meeting with Cassandra and her pediatric oncologist, Dr. Michael Isakoff, at which time she informed Dr. Isakoff that she never intended to undergo chemotherapy treatment and further stated that she told Judge Taylor at the contested OTC hearing that she would undergo treatment in order to convince the judge to return her to her mother's home. (Tr. 12/9/2014 at 37-38.) Cassandra also refused admission to the hospital for purposes of a psychiatric assessment and Mother continued to support Cassandra's decision not to undergo treatment for her curable cancer.

On December 1, 2014, DCF filed a Motion to Reargue/Reconsider/Clarification and to Reopen the evidence. (RJ, App., A46-A51.) In response, the court (*Quinn, J.*) held an

evidentiary hearing on December 9, 2014.[1] Following the evidentiary hearing, the court (*Quinn, J.*) found that Cassandra has advanced high risk Hodgkin's Lymphoma. Next, the court further determined that Respondent Mother was not credible and did not believe the diagnosis nor did she believe that her child needs treatment. The court also found that Cassandra lied when she testified that she would agree to treatment if she could go home. As a result, the court determined that Cassandra would remain in the custody of DCF, that Cassandra could not remain in her mother's home, and that DCF was authorized to make medical decisions regarding Cassandra's treatment.

### B. Facts Relating To Trial Court's Determination That Cassandra Is Not Capable of Making Mature Decisions On Her Own Behalf.

Cassandra lives with her mother and appears to have been raised exclusively by her mother since the age of seven. (Tr. 11/12/2014 at 11.) Cassandra's mother and father divorced when she was very young and, since then, Cassandra's father has not been involved in Cassandra's life. (*Id.* at 12.) Cassandra has also been homeschooled by her mother since her freshman year in high school. (*Id.* at 13.)

During her testimony at the OTC hearing, Cassandra asserted that she believed herself to be an adult. Cassandra based her belief on the fact that she is seventeen (17) years old, she has a job, and she saves her money to pay for her cell phone and clothing bills. (Tr. 11/12/2014 at 170; App. A42.) Cassandra later claimed that it was her decision, rather than her mother's decision, not to pursue treatment for her Hodgkins Lymphoma. (Tr. 11/12/2014 at 176.) Nevertheless, Cassandra changed her mind to seek treatment

[1] Judge Taylor was not available to hear the motion. Because of the urgency of the issue, the matter was heard by Judge Quinn. Before Judge Quinn was, among other evidence, the complete transcript of the OTC hearing and testimony of the child's treating physician, her DCF social worker and the mother.

after speaking with her best friend, Raelyn. She was not able to articulate a coherent reason for changing her mind. (*Id.* at 176-177.)

Dr. Feder was the first physician to point out how deferential Cassandra is to her mother. Dr. Feder described Cassandra as a sweet young woman who defers to her mother for making important decisions. (Tr. 11/12/2014 at 59-60.)

> Cassandra has always been quiet and sweet. And she defers when I'm with her to her mother. So she never – basically, it was more her mother speaking for her. So I would ask Cassandra, meaning, how is she doing and this that, and it was more through her mother. So Cassandra was always very courteous and nice to me. And I think Cassandra really relies on her mother to sort of take over for this problem in her neck.

(*Id.* at 59-60.)

Other medical providers who observed the interaction between Cassandra and her mother have, likewise, confirmed this description that mother dominates most medical appointment conversations and that Cassandra presented as withdrawn and not really participating in the conversations during the appointments. (Tr. 11/12/2014 at 12.) Dr. Isakoff noted his disappointment that Mother did not even bring Cassandra to their first appointment. (*Id.* at 117.)

Despite overwhelming evidence to the contrary, Cassandra testified at the OTC hearing that she never missed a medical appointment and she was not aware of her mother canceling medical appointments. (Tr. 11/12/2014 at 175.) Following Cassandra's removal from her home, Cassandra explained to DCF nurse consultant, Kimberly Kanaitis, that she was fearful of staying in the hospital, that she was afraid she would wake up and have "tubes sticking out of her." (Tr. 11/12/2014 at 38.) Interestingly enough, Cassandra also expressed concerns about not wanting to anger her mother because her mother was very distrustful of physicians. (*Id.*)

Following the November 12th OTC hearing, Cassandra began treatment then left her home without seeking further medical attention. After her return, Cassandra met with Dr. Isakoff, who testified:

> A. . . I talked to her about whether she was willing to do therapy or not and she indicated that she was not. I talked to her about the issues that we just reviewed; that if without treatment, that she would die of disease. And she acknowledged that she heard me saying that. She did not acknowledge that she necessarily agreed with me, but she didn't say anything to disagree.
>
> We – I reflected to her my concerns that her decision making seems to be quite poor and that I couldn't understand why she would not be continuing therapy after all of the things that we've talked about. She indicated to me and specifically told me that she only agreed to do the therapy so that she would get back in mom's home and told me that she would not – she knew that she wasn't going to continue the therapy once she started.
>
> To that, I told her that that decision was really a bad one in my opinion because it puts her in the position of getting partially treated, which then when she – if she decides later to get treated, could lead to her getting treated in a situation of resistant disease. And that if she really felt that way, I felt that she should have disagreed with the court order then and not put herself in a position where she could be affecting her own prognosis.
>
> Q: . . . she told you that she only agreed to the chemotherapy in order to get back into the home?
>
> A: That's correct.
>
> Q: Okay. But that when she said that, it was never her intention to follow through?
>
> A: That's correct. That's what she said.
>
> Q: . . . In your opinion, is she competent to make a decision such as that?
>
> A: Based on the conversations that I've had with her, I have felt that she's not competent. She did ask me specifically, you know, if I was eighteen, I wouldn't have this going on. And I acknowledged that if she was eighteen, there might be a different scenario going on. But I also told her that, in my opinion, if she was eighteen and making the decision not to get treated for a curable cancer, that that to me would put into question her competency even as a legal adult.

(Tr. 12/9/2014 at 15-17; App. A61-A63.)

He testified that Cassandra did not want to be exposed to chemotherapy, "toxic poisons", "but yet she was willing to get her therapy just to get home but not to cure her cancer. That disconnect is what raises her competency." (Tr. 12/9/2014 at 22; App. A67.) In Dr. Isakoff's extensive experience, this case is unique. He noted: "We've had patients not show up" to appointments, but eventually they end up treating. (Tr. 12/9/2014 at 25.)

Dr. Isakoff also testified that the Respondent Mother was either not a competent decision maker for her daughter or does not believe the diagnosis. (Tr. 12/9/2014, p. 18; App. A64.) He testified: "if its true that she doesn't believe the diagnosis, then there's a disconnect there too because we've had a second opinion in – Baystate that's confirmed the diagnosis. I have no question about the diagnosis. I even sent a pathology to Boston Children's Hospital so that they could look at it at Boston Children's and Dana Farber and they agreed with the diagnosis." (Tr. 12/9/2014 at 18; App. A64.)

Finally, Mother testified that she believed that her daughter was capable of making the decision to refuse life-saving treatment, against her wishes, because she "has that right as a human being." (Tr. 12/9/2014 at 44.) On Cassandra's behalf, her attorney argued: "My client's seventeen. She does not want to continue with treatment at this time . . . she doesn't feel sick and she'll do the chemotherapy when she's sick." (Tr. 12/9/2014, p. 52.)

The court (*Quinn, J.*), did not find Mother's testimony credible and further determined that neither Mother nor Cassandra were capable of making medical decisions on Cassandra's behalf. (Tr. 12/9/2014 at 55, 57; App. A69, A71.) As a result, the court vested medical decision making authority with the Department. (*Id.*)

In its articulation, the court (*Quinn, J.*), made the following findings of fact:

The court finds credible the testimony of Dr. Isakoff, the treating oncologist. He stated that Cassandra did not have the capacity to make sound medical decisions concerning her cancer treatment. His testimony and demeanor in court demonstrated his caring and thoughtful concerns for this adolescent. He spoke of the life threatening nature of Cassandra's cancer and that she had no chance of survival without treatment. With treatment, it is a curable disease and her five year survival chances, based on clinical trials, are excellent. In view of all the information which had been provided to Cassandra, her apparent willingness to undergo treatment while secretly knowing she would not, the consequences of such behavior on the efficacy of future treatment, and the totality of all the facts she knew, Dr. Isakoff concluded that she did not have such capacity. And the court agrees and so finds.

The court observed Cassandra's demeanor at trial as well and saw how closely she followed her mother's testimony and hung on her every word. The DCF investigations worker testified on November 12, 2014 that Cassandra and her mother are close. She noted that Cassandra's mother did not appear to be in support of the chemotherapy and that Cassandra is concerned about going against what her mother would like to see happen.

On December 9, 2014, Cassandra's mother testified that Cassandra is a bright intelligent girl and that she can make her own decisions. She stated she believed it was Cassandra's right as a human being to decide whether to accept chemotherapy. She asserted her daughter was competent and old enough.

Such assertions are problematic, however, and without adequate support in the testimony and facts of this case. The doctors had reported to DCF that Cassandra's mother dominated most medical appointment conversations, during which Cassandra was withdrawn and not participating a great deal. The record is replete with her mother's arguments with physicians about the diagnosis, her seeking three separate opinions about the diagnosis, attempting to change pediatricians and delaying follow-up appointments and needed treatment. The court concludes that Cassandra's mother has engaged in a passive refusal to follow reasonable medical advice for her mortally ill child. Her refusal brought about the physicians' referral to DCF in the first instance.

Cassandra is a child that has been homeschooled since the ninth grade and is totally dependent on her mother, her sole caretaker, as her father is not involved in her life. She has no siblings. She does not possess the necessary level of maturity or independence to make life and death decisions about her own medical care, as demonstrated both by her conduct and her behavior subsequent to the initial court order. The court finds, from the testimony and its observations of both the mother's and Cassandra's demeanor at

> trial, that Cassandra is overshadowed by the strong negative opinions her mother holds about her cancer diagnosis and treatment, including chemotherapy. . .
>
> The second question concerning Cassandra's maturity is, in large part, answered by the court's findings above. The court has only heard brief testimony by the mother concerning Cassandra's maturity. The court gives greater weight to the testimony that she is not very mature. The physician's thoughtful assessment of her capacity, the court's own observations of the parties and the witnesses, the observations of the DCF investigations worker and Cassandra's own actions all support the conclusion that she is an immature seventeen year old. She is not yet fully separated or independent of her mother. She engages in compulsive and risky actions and is unable or unwilling to speak her true mind to those in authority. While the court does not conclude that her mother has coerced her into her present position of refusing treatment, the court does find that her life circumstances make it difficult for her to hold opinions her mother does not share.
>
> The court finds, from all the facts, that Cassandra is not a mature minor. She is as yet incapable of acting independently concerning her own life threatening medical condition. And time is running out for the recommended course of treatment to have a positive outcome for her future.

(Articulation of Judge Barbara Quinn dated December 24, 2014.)

## I. LEGAL ARGUMENT

**INTRODUCTION:**

"Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments." *Parham* v. *J. R.*, 442 U.S. 584, 603-04 (1979). The Respondent Mother and the child argue for the first time on appeal that Cassandra is a "mature minor" – under this theory minors deemed by the court "mature" may make medical decisions for themselves -- and that the court's order directing that she get lifesaving treatment violated her right to due process. Under the case law of the smattering of jurisdictions that have adopted the mature minor concept as a matter of common law in

this context, the burden of proof is upon the party seeking to apply this exception to establish the child's maturity by clear and convincing evidence. *In re E.G.*, 133 Ill. 2d 98, 549 N.E.2d 322 (1989); *Application of Long Island Jewish Med. Ctr.*, 147 Misc. 2d 724, 727, 557 N.Y.S.2d 239, 241-42 (Sup. Ct. 1990). As the Supreme Court of Illinois noted, the clear and convincing evidence standard is necessary because "A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize." *In re E.G.*, *supra*.

An evidentiary hearing was held before Judge Quinn to determine the child's competency or maturity to make medical decisions. The court found:

> The physician's thoughtful assessment of her capacity, the court's own observations of the parties and the witnesses, the observations of the DCF investigations worker and Cassandra's own actions all support the conclusion that she is an immature seventeen year old. She is not yet fully separated or independent of her mother. She engages in compulsive and risky actions and is unable or unwilling to speak her true mind to those in authority. While the court does not conclude that her mother has coerced her into her present position of refusing treatment, the court does find that her life circumstances make it difficult for her to hold opinions her mother does not share.
>
> The court finds, from all the facts, that Cassandra is not a mature minor. She is as yet incapable of acting independently concerning her own life threatening medical condition. And time is running out for the recommended course of treatment to have a positive outcome for her future.

(Trial Court's Articulation, pp. 4-5)

Even if this Court were to adopt the mature minor theory, there is no factual basis for its application to the present case. The evidentiary record was uncontroverted that Cassandra suffers from a potentially fatal illness. Unless Cassandra gets the lifesaving treatment for her cancer, she will die. If she gets the recommended treatment, there is an excellent chance that she will make a full recovery. Although the appellants paint with a

broad brush that this case is about the right to bodily integrity, what this case is really about is whether a 17 year old girl, who has been found by the trial to lack maturity and the capacity to make sound decisions on her own behalf, should be allowed to die, and whether the state should be complicit in her "immature, foolish decision." *In re E.G.*, supra. The state has a compelling interest in the welfare of children, even an older child such as Cassandra. Whatever interest the child may have in self-determination, such an interest is outweighed by the state's paramount interest in preserving her life. The trial court's decision should be affirmed.

**TRIAL COURT DID NOT ABUSE ITS DISCRETION IN APPOINTING DCF AS MEDICAL DECISION MAKER FOR CASSANDRA, AND THAT DECISION WAS AUTHORIZED BY CONNECTICUT LAW.**

The welfare of children is a compelling interest. Conn. Gen. Stat. § 17a-101 (a); *Dutkiewicz* v. *Dutkiewicz*, 289 Conn. 362, 382 (2008); *In re Juvenile Appeal (83-CD)*, 189 Conn. 276, 287-88 (1983). Cassandra is under the temporary custody of DCF, the court having found that she would be in immediate risk of physical harm from her surroundings. Conn. Gen. Stat. § 46b-129 (b). The basis of the trial court's decision is the respondent's failure to secure medical treatment for her child for a curable form of cancer, which, if left untreated, is fatal. In proceedings in the superior court for juvenile matters, the "petitioner acts . . . for the state as parens patriae, to ensure, first and foremost the child's safety." *In re Allison G.*, 276 Conn. 146, 158-59 (2005).

The trial court has broad authority to make orders to "secure the welfare, protection, proper care and suitable support of a child or youth subject to the court's jurisdiction or otherwise committed to or in the custody of the Commissioner of Children and Families." Conn. Gen. Stat. § 46b-121 (b). These broad powers extend to ordering medical treatment

of the child or youth. *See* Practice Book §§ 33a-8, 34a-23; *cf.* Conn. Gen. Stat. § 18-81d. *See also* Conn. Gen. Stat. § 46b-129 (b) (the temporary custodian has the "authority to make decisions regarding emergency medical, psychological, psychiatric or surgical treatment."); Cf. Conn. Gen. Stat. § 45a-608.

Here, however, the OTC orders issued by Judge Taylor followed the testimony of the child and the mother that they were in agreement with receiving medical treatment as recommended by CCMC so long as the child was returned to the Respondent Mother's home. As later found by Judge Quinn, however, the child misrepresented her intentions and thereby attempted to "hoodwink" the court. (T. 12/9/2014, p. 56.) That became readily apparent when Cassandra fled and her mother refused to help locate her. It was at that point that the Department chose to bring the case back to court in order to obtain a specific order authorizing medical treatment. It was in the course of that hearing that the trial court heard testimony from Dr. Isakoff, her treating physician, that Cassandra was not competent to decide her fate. The trial court found that to be the case based soundly on the testimony of Dr. Isakoff that Cassandra "did not have the capacity to make sound medical decisions regarding her cancer treatment." (Articulation, p. 3.) The court found that Cassandra "does not possess the necessary level of maturity or independence to make life and death decisions about her own medical care, as demonstrated both by her conduct and her behavior subsequent to the initial court order." (Articulation, p. 4.) "We do not examine the record to determine whether the trier of fact could have reached a conclusion other than the one reached.... [Rather] every reasonable presumption is made in favor of the trial court's ruling." (Citations omitted; internal quotation marks omitted.) *In re Melody L.*, 290 Conn. 131, 145 (2009); *In re Samantha C.*, 268 Conn. 614, 627-628 (2004).

Significantly, this is not a case in which either the medical evidence was ambiguous or that the odds were against the child making a full recovery.[2] Indeed, the uncontroverted medical evidence is that, if treatment is not delayed, it is highly likely that the child will make a full recovery. Nor is this a case in which the refusal of treatment was based upon religious conviction.[3] Indeed, the one time the child testified (at the OTC hearing) she indicated that she was willing to engage in the recommended treatment so long as she was sent home to her mother.

"Connecticut has a policy of preserving life. Indeed, 'doctors are trained ... in order to provide care and treatment for sick and dying patients. The preservation of life is not only a laudable goal for ... the physicians ... to aspire to, it is a compelling one.'" *Comm'r of Correction* v. *Coleman*, 303 Conn. 800, 819 (2012), *cert. denied sub nom. Coleman* v. *Arnone*, 133 S. Ct. 1593, 185 L. Ed. 2d 589 (2013).

"[T]he medically indicated treatment program offers the child [her] only real chance of survival. Consequently, the State interest in the preservation of life applies with full force." *Custody of a Minor*, 375 Mass. 733, 755, 379 N.E.2d 1053, 1066 (1978) (child removed so that he could receive chemotherapy to save his life). The trial court did not abuse its discretion in appointing DCF as medical decision maker for the child; the factual

---

[2] *Compare Newmark* v. *Williams*, 588 A.2d 1108 (Del. 1991) (deciding to not order child with cancer to undergo radical form of treatment with a low likelihood of success).

[3] See, e.g., *In re Willmann*, 493 N.E.2d 1380, 1390 (Ohio App. 1986) (holding the religious beliefs of parents did not justify refusing an operation to remove a life-threatening tumor from the arm of their seven-year-old son); *In re Hamilton*, 657 S.W.2d 425, 429 (Tenn. App. 1983) (ordering a 12-year-old girl to undergo chemotherapy and radiation to treat Ewing's Sarcoma, over the religious-based objections of her father). *See* Jessica A. Penkower, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment-Fatal Misuse of the Mature Minor Doctrine*, 45 DePaul L. Rev. 1165, 1216 (1996).

findings underpinning that decision were not clearly erroneous. Furthermore, that decision is fully authorized by and consistent with Connecticut law.

**THIS CASE DOES NOT PRESENT AN OPPORTUNITY FOR THIS COURT TO DECIDE WHETHER TO ADOPT THE MATURE CHILD EXCEPTION AS A MATTER OF COMMON LAW.**

Appellate counsel relies on the Mature Child concept, under which some minors have been deemed to have sufficient maturity to make medical decisions on their own behalf. (Joint Brief, pp. 8-14.) The Mature Minor exception "permits a minor who exhibits the maturity of an adult to make decisions traditionally reserved for those who have attained the age of majority." Ann Eileen Driggs, R.N., *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?,* 11 Health Matrix 687, 696-97 (2001).

Even if the Mature Child concept were applicable, the trial court (*Quinn, J.*) has found that Cassandra does not have the maturity of judgment to make medical decisions on her own behalf. The evidence showed that she was willing to undergo treatment in order to be returned home, but was unwilling to undergo treatment in order to save her life from her fatal illness. Moreover, Cassandra stopped treatment after two days of chemotherapy; fleeing her home and not seeking medical attention during the week that she was in hiding from the Department. Her treating physician opined that her choices were irrational, and that she did not have the capacity to make sound medical decisions on her own behalf. Based upon the evidence, the court appointed DCF her temporary custodian, and to make medical decisions on the child's behalf.

Perhaps it is stating the obvious, but adolescence is a period of change and turmoil and, at times, insecurity and rebellion. At least in part, the ability to make mature decisions is a function of life experience, in other words, having the opportunity to practice making

important decisions over time and learning from one's mistakes. By virtue of her young age, Cassandra has not had the opportunity to develop the ability to make mature decisions. "[A]s any parent knows and as the scientific and sociological studies . . . tend to confirm, [a] lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults and are more understandable among the young. These qualities often result in impetuous and ill-considered actions and decisions. ... In recognition of the comparative immaturity and irresponsibility of juveniles, almost every State prohibits those under 18 years of age from voting, serving on juries, or marrying without parental consent." (Internal citations and quotations omitted.) *Roper* v. *Simmons*, 543 U.S. 551, 569-70 (2005).

On top of that, Cassandra faces a life threatening disease.

> Research has shown that chronic or serious illness may leave the minor with a feeling of uncertainty about the future and doubt that he will ever be happy. These adolescents are also more likely to develop major psychosocial problems than those who are healthy. Researchers have also found that serious or chronic illness has a potential impact on developmental tasks during adolescence. Risk-taking behavior may increase, self-esteem may be lowered, emotional difficulties may increase, and the sense of personal identity may be compromised. It would seem that these factors would then adversely affect the adolescent's decision-making capabilities. It would be difficult, at best, for the adolescent to make a decision that is not distorted by these factors at a time when his health is so compromised.

(Footnotes omitted.) Ann Eileen Driggs, R.N., *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?,* 11 Health Matrix 687, 707 (2001).

The few courts that have considered the issue and adopted the mature minor theory as a matter of common law in the context of deciding whether a minor should undergo treatment, have held that the minor must prove her maturity by clear and convincing evidence. *In re E.G.*, 133 Ill. 2d 98, 549 N.E.2d 322 (1989); *Application of Long Island Jewish Med. Ctr.*, 147 Misc. 2d 724, 727, 557 N.Y.S.2d 239, 241-42 (Sup. Ct. 1990). As

expressly found by the trial court herein, Cassandra is not a "mature minor." (Articulation, p. 5.) In the absence of a factual record to demonstrate that Cassandra is a mature minor, this Court need not address whether to adopt the mature minor doctrine. *See O.G.* v. *Baum*, 790 S.W.2d 839, 842 (Tex. App. 1990) (no need to consider whether mature minor doctrine should be adopted because factual record did not support that minor was, in fact, mature). Indeed, based on this record, the petitioner strongly suggests that any such adoption would be tantamount to an advisory opinion, something that this Court traditionally frowns upon. *Echavarria* v. *Nat'l Grange Mut. Ins.* Co., 275 Conn. 408, 419 (2005).

**MATURE MINOR EXCEPTION WOULD NOT APPLY TO CASSANDRA.**

**A. Connecticut Legislature Has Not Chosen To Adopt Mature Minor Concept.**

Even if this Court were inclined to adopt the mature minor concept, this would not be the appropriate case for its application. The Connecticut legislature has authorized minors to make decisions relative to limited medical issues under clearly circumscribed circumstances.[4] Minors may consent to the provision of outpatient mental health treatment without parental consent under limited circumstances.[5] In discrete areas, when there is a strong societal interest in a minor obtaining medical treatment where having to involve parents might lead a minor to forego treatment, the legislature has allowed minors to

---

[4] Not surprisingly, minors who are emancipated may consent to medical care without parental consent. Conn. Gen. Stat. § 46b-150d.

[5] Minors may consent to outpatient mental health treatment if "(1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively." Conn. Gen. Stat. § 19a-14c. In general, "[p]arental consent shall be necessary for [mental health] treatment." except if "such consent is withheld or immediately unavailable and the physician concludes that treatment is necessary to prevent serious harm to the child, such emergency treatment may be administered pending receipt of parental consent." Conn. Gen. Stat. § 17a-81.

consent under limited circumstances. For example, a minor may seek examination and treatment of venereal disease without parental consent; Conn. Gen. Stat. § 19a-216; and for HIV or Aids if a "physician determines that notification of the parents or guardian of the minor will result in treatment being denied or the physician determines the minor will not seek, pursue or continue treatment if the parents or guardian are notified and the minor requests that his parents or guardian not be notified"; Conn. Gen. Stat. § 19a-592; and for drug and alcohol treatment; Conn. Gen. Stat. § 17a-688; and abortion. Conn. Gen. Stat. § 19a-601.[6]

Having carved out these particular areas in which minors may make medical decisions under limited circumstances, it is significant that the Connecticut legislature has not adopted the mature child exception to the usual rule that medical decisions must be made by a child's parent. Cassandra does not fall within the limited categories designated by the legislature under which minors may make decisions relative to specific issues.[7] Furthermore, the legislative policy as evidenced by these statutes does not support the

---

[6] "[T]here is no indication that the treatment exceptions are founded on consideration of the minors' actual decision-making capabilities. . . . treatment exceptions seem to be an extension of the state's *parens partriae* authority; however, rather than the state stepping in, it gives decision-making authority directly to minors. Another policy behind the treatment exceptions stems from public health and safety. Adolescents may be hesitant to inform their parents of their sexual activity or substance abuse problems, and therefore will forego medical treatment. Allowing minors to consent to these treatments without involving their parents removes a substantial obstacle." Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs*, 22 J. Contemp. Health L. & Pol'y 233, 256 (2006).

[7] A small number of states have open-ended statutes that provide that minors have the legal capacity to consent to medical treatment, such as: Alabama, Al. Stat. Ann. 22-8-4 (minors age 14 and over who have graduated from high school, married or pregnant have authority to consent); Arkansas, Ar. Stat. Ann. 20-9-602 (7); Idaho, Id. Stat. Ann. 39-4503 (minors capable of meeting informed consent standard have authority to consent). *See* Dariane Lambelet Colemen and Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, Pediatrics (2013). (http://pediatrics.aapublications.org/content/131/4/786.full.html).

claim that the mature minor concept should be adopted in Connecticut. Indeed, the legislature's recent enactment of the "raise the age" statute evidences the legislature's concern that minors ages 16-18 do not necessarily make mature decisions and, therefore, are permitted to remain in the juvenile court system to benefit from a restorative justice model. *See* Conn. Gen. Stat. § 46b-120, Public Act No. 07-4, 09-7.

### B. Even If Mature Minor Concept Were Adopted In Connecticut, Cases From Other Jurisdictions Do Not Support Its Application To Present Case.

"Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments." *Parham* v. *J. R.*, 442 U.S. 584, 603-04 (1979).[8] "At common law, minors generally were considered to lack the legal capacity to give valid consent to medical treatment or services, and consequently a parent, guardian, or other legally authorized person generally was required to provide the requisite consent. In the absence of an emergency, a physician who provided medical care to a minor without such parental or other legally authorized consent could be sued for battery." *Am. Acad. of Pediatrics* v. *Lungren*, 16 Cal. 4th 307, 314-15, 940 P.2d 797, 800 (1997) ("The requirement that medical care be provided to a minor only with the consent of the minor's parent or guardian remains the general rule, both in California and throughout the United States."). Minor children may not make medical decisions on their own behalf. The minor's parent or guardian must make medical decisions on behalf of the minor. See Conn. Gen. Stat. §17a-1 (12). This rule is appropriate in light of "the peculiar vulnerability of children;

---

[8] Even an adult's self-determination is not absolute. In the case of an adult, the probate court may appoint a conservator of the person to make medical decisions for an incapable adult if the basis for that order is established by clear and convincing evidence. Conn. Gen. Stat. §§ 45a-650, 45a-656.

their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." *Bellotti* v. Baird, 443 U.S. 622, 634 (1979).

Many of the cases that address the mature minor concept do so in the context of litigating tort liability.[9] The seminal case regarding the notion of the mature child is *Cardwell* v. *Bechtol*, 724 S.W.2d 739, 741 (Tenn. 1987). There, after experiencing back pain, without her parents' knowledge, Sandra Cardwell (aged seventeen years, seven months) visited an osteopathic physician who had treated her father in the past. The physician misdiagnosed her condition and proceeded to treat her through manipulations of the neck, spine and legs. She suffered complications from the treatment. She filed an action for damages against the osteopathic physician, and specifically, a claim of battery for having treated the patient without the consent of her parents. The jury instructions included the mature minor exception to the requirement of parental consent to perform medical treatment on a minor. A general verdict was returned for defendant. On appeal to the state Supreme Court, the question was whether the physician could be held liable in battery for failing to obtain consent from the parents. The state Supreme Court in Tennessee elected to adopt the notion of the mature minor, but made clear: "Adoption of the mature minor exception to the common law rule is by no means a general license to treat minors without parental consent and its application is dependent on the facts of each case." *Id.*, 745. The Tennessee Supreme Court made clear that it was not stating a bright line rule that adolescents and

---

[9] The root of the mature minor concept "was based less on concern about children's rights than on the desire to negate a battery action against medical personnel if an older minor consented in near-emergency situations or when a parent was unavailable." Walter Wadlington, *David C. Baum Memorial Lecture: Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. Ill. L. Rev. 311, 321-22 (1994).

children would automatically be considered "mature", stating that maturity presented a question of fact based upon all of the circumstances. *Id.*, 748.

In *Belcher* v. *Charleston Area Med. Ctr*, 188 W. Va. 105, 116, 422 S.E.2d 827, 838 (1992), parents of 17 year old child who died after hospital staff followed a "do not resuscitate" order after minor's respiratory arrest sued hospital and treating physician for wrongful death, alleging lack of informed consent. The plaintiffs claimed that the physician should have consulted with the minor because the minor was "mature" prior to issuing the "do not resuscitate order" even though the parents told the physician that they did not want the child involved in the decision making process, and they agreed to the order. The trial court did not allow the case to go to the jury on the mature minor theory. On appeal, the West Virginia Supreme Court held that the trial court erred in failing to instruct the jury that it should have considered the child's maturity level in assessing whether the child's consent should have been obtained. In the context of this tort case, the court adopted the concept of the mature child, reasoning:

> we hold that except in very extreme cases, a physician has no legal right to perform a procedure upon, or administer or withhold treatment from a patient without the patient's consent, nor upon a child without the consent of the child's parents or guardian, unless the child is a mature minor, in which case the child's consent would be required. Whether a child is a mature minor is a question of fact.

*Belcher v. Charleston Area Med. Ctr.*, 188 W. Va. 105, 116, 422 S.E.2d 827, 838 (1992).

"When the circumstances involve a life-threatening situation, courts have generally not extended the right to reject life sustaining treatment to minors and are reluctant to apply the mature minor doctrine." Ann Eileen Driggs, R.N., *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?,* 11 Health Matrix 687, 696 (2001).

One exception, with facts very different from the present case, is *In re E.G.*, 133 Ill. 2d 98, 549 N.E.2d 322 (1989). In E.G., a 17-year-old girl, was diagnosed with leukemia and needed blood transfusions in the treatment of the disease. E.G. and her mother refused to consent to the transfusions, contending that acceptance of blood would violate personal religious convictions rooted in the Jehovah's Witness faith. The State of Illinois filed a neglect petition in juvenile court in the circuit court of Cook County. The trial court entered an order finding E.G. to be neglected, and appointed a guardian to consent to the transfusions on E.G.'s behalf. The appellate court reversed the trial court in part. The appellate court held that E.G. was a "mature minor," and therefore could refuse the blood transfusions through the exercise of her first amendment right to freely exercise her religion. Nevertheless, the court affirmed the finding of neglect against the mother.

In E.G., expert testimony established that the "[t]he long-term prognosis [was] not optimistic, as the survival rate for patients such as E.G. is 20 to 25%." *In re E.G.*, 133 Ill. 2d 98, 102, 549 N.E.2d 322, 323 (1989). Her treating physician testified: "that he discussed the proposed course of treatment with E.G. He testified that E.G. was competent to understand the consequences of accepting or rejecting treatment, and he was impressed with her maturity and the sincerity of her beliefs." *Id.* at 101. "Several other witnesses gave their opinions extolling E.G.'s maturity and the sincerity of her religious beliefs." *Id.* at 103. On appeal, the Illinois Supreme Court adopted the mature minor exception, but set forth strict limitations on its application. The Illinois Supreme Court stated:

> The trial judge must determine whether a minor is mature enough to make health care choices on her own. . . . We feel the intervention of a judge is appropriate for two reasons. First, Illinois public policy values the sanctity of life. . . . When a minor's health and life are at stake, this policy becomes a critical consideration. A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize. Consequently, when the trial

> judge weighs the evidence in making a determination of whether a minor is mature enough to handle a health care decision, he must find proof of this maturity by clear and convincing evidence.
>
> Second, the State has a *parens patriae* power to protect those incompetent to protect themselves..."[I]t is well-settled that the State as *parens patriae* has a special duty to protect minors and, if necessary, make vital decisions as to whether to submit a minor to necessary treatment where the condition is life threatening, as wrenching and distasteful as such actions may be." .... Where the health care issues are potentially life threatening, the State's *parens patriae* interest is greater than if the health care matter is less consequential. Therefore, the trial judge must weigh these two principles against the evidence he receives of a minor's maturity. If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or refuse medical treatment.

*Id.* at 110-111.

The present case is easily distinguishable from E.G. based on an evidentiary record that revealed clear and convincing evidence that the minor was competent and mature, and that her position was sincerely based upon religious conviction. Here, there is no finding by clear and convincing evidence that the minor is mature or has based her decisions on any principled conviction. (Articulation, p. 3.) Indeed, the trial court specifically found that Cassandra was <u>not</u> a mature minor. (Articulation, p. 5.) In E.G., the prognosis was poor. Fortunately, in the present case the medical evidence was uncontroverted that if Cassandra were treated, she would have an excellent chance to make a full recovery without any significant long-term impact on her health; conversely, if left without treatment, Hodgkin's Lymphoma is "universally fatal." (App. A33.) Furthermore, the evidence showed that delayed treatment would increase the risk of developing other forms of cancer. "Where the health care issues are potentially life threatening, the State's *parens patriae* interest is greater than if the health care matter is less consequential." *Id.* Using the test articulated in

E.G. it is unquestionable that Cassandra would not be found to be a mature minor, particularly given the requirement that maturity be proven by clear and convincing evidence. As warned by the Illinois Supreme Court it is critical that there be a judicial finding of maturity by clear and convincing evidence -- because otherwise "[a] minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize." *Id.*

Following E.G., other courts have found that the minor in question lacks maturity to make his or her own medical decisions.[10] *See Application of Long Island Jewish Med. Ctr.,* 147 Misc. 2d 724, 730, 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990) ("I find that Phillip Malcolm is not a mature minor. Therefore, his refusal to consent to blood transfusions is not based upon a mature understanding of his own religious beliefs or of the fatal consequences to himself"); *In re A.M.P.*, 303 Ill. App. 3d 907, 912, 708 N.E.2d 1235, 1239 (1999) ("A.M.P.'s parents and her physician wisely sought guidance from the trial court before proceeding with ECT so that her rights, as discussed in *E.G.,* were not denied. A.M.P. was present in the courtroom during the proceedings and, except for becoming agitated when her name was mentioned, did not react to the discussion of the proposed therapy. She is clearly not a mature minor, capable of making her own decisions regarding treatment of her psychosis."). *See also In the Matter of the Child of Colleen Hauser, et al.*; Docket No. JV-09-068 (Fifth Judicial District, Minn., May 15, 2009) (13 year old had "only a rudimentary understanding at best of the risks and benefits of chemotherapy. He genuinely opposes the

[10] The appellants cite *In re Swan*, 569 A.2d 1202 (Me. 1990). That case is not a mature minor case. It involved an adult patient who was in a car accident and was in a persistent vegetative state without hope of improvement. Prior to the car accident and prior to turning 18, the patient expressed his desire not to be kept alive under such circumstances. The court held that it was appropriate to consider such statements, reasoning: "The fact that [the patient] made these declarations as to medical treatment before he reached the age of 18 is at most a factor to be considered by the factfinder in assessing the seriousness and deliberativeness with which his declarations were made." *Id.*, 1205.

imposition of chemotherapy. However, he does not believe he is ill currently. The fact is that he is very ill currently. He has Hodgkin's lymphoma . . . [T]he state has a compelling state interest sufficient to override the minor's genuine opposition.")

Other courts have elected not to adopt the mature minor exception. *See, e.g., Novak* v. *Cobb Cnty.-Kennestone Hosp. Auth.*, 849 F. Supp. 1559, 1576 (N.D. Ga. 1994) *aff'd sub nom. Novak* v. *Cobb Cnty. Kennestone Hosp. Auth*, 74 F.3d 1173 (11th Cir. 1996) ("[T]he Court finds that Georgia provides no 'mature minor' exception to its general rule that only adults may refuse unwanted medical care."); *Com.* v. *Nixon*, 563 Pa. 425, 761 A.2d 1151 (2000) (Maturity of the victim, an unemancipated minor, was not an affirmative defense to charges of involuntary manslaughter and endangering the welfare of a child against victim's parents for failing to obtain medical treatment for victim); *O.G.* v. *Baum*, 790 S.W.2d 839, 842 (Tex. App. 1990) (factual record provided no occasion for adopting the mature minor doctrine). In sum, case law from other jurisdictions does not support application of the mature minor exception to Cassandra.

**TRIAL COURT'S ORDER ALLOWING THE CHILD TO RECEIVE LIFE-SAVING TREATMENT DOES NOT VIOLATE SUBSTANTIVE DUE PROCESS.**

The gravamen of this case is that the respondent mother committed child neglect in failing to secure life-saving treatment for her daughter. Cassandra is in DCF's temporary custody, the court having found that she would be in immediate risk of physical harm from her surroundings. In the subsequent hearing before Judge Quinn, the court found:

> The record is replete with her mother's arguments with physicians about the diagnosis, her seeking three separate opinions about the diagnosis, attempting to change pediatricians and delaying follow-up appointments and needed treatment. The court concludes that Cassandra's mother has engaged in a passive refusal to follow reasonable medical advice for her mortally ill child. Her refusal brought about the physicians' referral to DCF in the first instance.

> Cassandra is a child that has been homeschooled since the ninth grade and is totally dependent on her mother, her sole caretaker, as her father is not involved in her life. She has no siblings. . .The court finds, from the testimony and its observations of both the mother's and Cassandra's demeanor at trial, that Cassandra is overshadowed by the strong negative opinions her mother holds about her cancer diagnosis and treatment, including chemotherapy. . .

(Articulation, p. 4.)

Although there was strong evidence of Cassandra's lack of capacity to make mature decisions on her own behalf, at its heart this case is about child neglect committed by the Respondent Mother.

"The state has a substantial interest in protecting minor children . . . intervention in family matters by the state is justified, however, only when such intervention is actually 'in the best interests of the child,' a standard long used in this state." *In re Juvenile Appeal (83-CD)*, 189 Conn. 276, 285 (1983). The protection of children is a compelling interest. Conn. Gen. Stat. § 17a-101 (a); *Dutkiewicz* v. *Dutkiewicz*, 289 Conn. 362, 382 (2008). "Intervention is permitted only where 'serious physical illness or serious physical injury' is found or where "immediate physical danger" is present. It is at this point that the child's interest no longer coincides with that of the parent, thereby diminishing the magnitude of the parent's right to family integrity . . . and therefore the state's intervention as parens patriae to protect the child becomes so necessary that it can be considered paramount." *In re Juvenile Appeal (83-CD)*, 189 Conn. 276, 287-88 (1983). "The constitutional privileges attached to the parent-child relationship . . . are hardly absolute. Although parents enjoy a constitutionally protected interest in their family integrity, this interest is counterbalanced by the compelling governmental interest in the protection of minor children, particularly in circumstances where the protection is considered necessary as against the parents

themselves." (Internal quotation marks omitted.) *United States* v. *Myers*, 426 F.3d 117, 125 (2d Cir. 2005). *See Prince* v. *Massachusetts,* 321 U.S. 158, 170 (1944) ("Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.")

The superior court has ordered that DCF be the child's temporary custodian and, thereafter, the child's medical decision maker. The court, following an evidentiary hearing, found that neither the child nor the mother were competent decision makers. As reflected in the evidentiary record, at every step along the way the Department of Children and Families sought to persuade the mother and child to obtain treatment. Under the superior court's order the Department removed the child from the mother's sphere of influence--the mother apparently supported the child's disregard of the medical opinions that she would die without treatment and that she had an excellent chance of full recovery with treatment. The Department arranged for psychological intervention at CCMC. Unfortunately, because the child does not feel ill at this time, she apparently does not understand that not engaging in treatment will result in her own death.

The Respondent Mother, having delayed treatment since the child's diagnosis on September 12, 2014, and the Department, having sought and obtained the order of temporary custody on November 14, 2014, before Judge Taylor and having obtained further orders from Judge Quinn on December 9, 2014 , and having then arranged for mental health intervention for the child at CCMC for some eight days, morally and legally the Commissioner of the Department of Children and Families is duty-bound to obtain

treatment for Cassandra. To do otherwise would make her complicit in what is, in effect, the child's suicide.[11]

"In almost every State-indeed, in almost every western democracy--it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life." *Washington* v. *Glucksberg*, 521 U.S. 702, 710-11 (1997). Such self injurious actions are tragic enough in an adult. To stand by and permit a child to, in effect, commit suicide by refusing life-saving treatment which will likely offer her a full recovery would be unconscionable and antithetical to this state's child protection statutes.

The appellant's due process claim was not raised below.[12] Although the appellants invoke the right to bodily integrity, they identify no authority that supports the application of this concept to a child who is in desperate need of life saving medical treatment, was neglected by her parent, and therefore dependent upon the state to step in and save her

---

[11] Dr. Isakoff testified: Q: And so in terms of – you're aware that the Department removed Cassandra from her home. If you were to learn, doctor, that Cassandra would refuse treatment if she is not returned home, what would your response be to that?
A: Well, I would personally be sad. I think that that would be the wrong decision for anybody to make when they have a curable disease. **I think that the decision not to treat is to me the same as making a decision to commit suicide.** I think that that is – you know, it's a sad and horrible decision to make, and you know, sort of makes me concerned that there's a disbelief that this is happening. . . (Emphasis added) Tr. 11/12/14 at 131.

[12] "It is well settled that the trial court can be expected to rule only on those matters that are put before it. . . . With only a few exceptions . . . we will not decide an appeal on an issue that was not raised before the trial court. . . . To review claims articulated for the first time on appeal and not raised before the trial court would be nothing more than a trial by ambuscade of the trial judge." (Internal quotation marks omitted.) *United Technologies Corp.* v. *CHRO*, 72 Conn. App. 212, 223-224, *cert. denied*, 262 Conn. 920 (2002).

life. The appellants have failed to establish that the alleged constitutional violation clearly exists. *State* v. *Golding*, 213 Conn. 233, 239-240 (1989).[13]

**HEARING AFFORDED ALL PARTIES PROCEDURAL DUE PROCESS.**

The Respondent Mother and child claim that the hearing violated procedural due process because there was no expert psychiatric or psychological testimony to directly address whether the minor was a "competent" decision maker for purposes of determining whether the child was a mature minor. (Joint Brief, pp. 22-37.) It should be underscored that the mature minor exception has not been adopted in this state. Nor did the respondent mother or the child, both of whom were represented by separate counsel, raise the claim that Cassandra was a mature minor. Nonetheless, in asking for appointment as the medical decision maker for the child, the Department asked the court to address the "competency" of the minor to make medical decisions on her own behalf. The Department filed a motion to reconsider and reopen the evidence, requesting: "Petitioner respectfully requests that this honorable court reopen the evidentiary portion of the contested OTC hearing in order to consider evidence regarding the child's subsequent behaviors and whether she is competent to make life/death decisions regarding her medical care." (RJ, App., A49) In response, an evidentiary hearing was held on December 9, 2014, to address that issue. Although the mature minor claim was not explicitly raised, all parties had a full

[13] In *State* v. *Golding*, 213 Conn. 233, 239-240 (1989), this Court held that a party "can prevail on a claim of constitutional error not preserved at trial only if all of the following conditions are met: (1) the record is adequate to review the alleged claim of error; (2) the claim is of constitutional magnitude alleging the violation of a fundamental right; (3) the alleged constitutional violation clearly exists and clearly deprived the defendant of a fair trial; and (4) if subject to harmless error analysis, the state has failed to demonstrate harmlessness of the alleged constitutional violation beyond a reasonable doubt. In the absence of any one of these conditions, the defendant's claim will fail."

opportunity to address the issue of the child's competency, including the opportunity to present evidence on this issue and to cross examine witnesses. As used in criminal and juvenile proceedings, lack of "competency" is defined as: "A person is 'not competent if he is unable to understand the proceedings against him or to assist in his own defense.'" *In re Alexander V.*, 223 Conn. 557, 562 n. 4 (1992). In most circumstances, expert opinion evidence is required to make such a determination.

This is not the applicable definition of competency in this context. Rather, as Judge Quinn interpreted the standard—the court must look at the totality of the circumstances, and determine whether the child had the "capacity to make sound medical decisions concerning her cancer treatment." (Articulation, p. 3.) Other courts that have adopted the mature minor exception have engaged in a similar broad inquiry to determine the child's maturity to make such decisions. The trial court's analysis is consistent with those cases that have adopted the exception. *Cardwell* v. *Bechtol*, 724 S.W.2d 739, 741 (Tenn. 1987) ("Whether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences are to be considered"); *Belcher* v. *Charleston Area Med. Ctr*, 188 W. Va. 105, 116, 422 S.E.2d 827, 838 (1992) ("Whether a child is a mature minor is a question of fact. Whether the child has the capacity to consent depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the child, as well as upon the conduct and demeanor of the child at the time of the procedure or

treatment. The factual determination would also involve whether the minor has the capacity to appreciate the nature, risks, and consequences of the medical procedure to be performed, or the treatment to be administered or withheld.").

Furthermore, the primary case upon which the respondent mother and child rely, is the E.G. case. There, the Illinois Supreme Court makes clear that the burden is on the party invoking the mature child concept to prove maturity by clear and convincing evidence.

> A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize. Consequently, when the trial judge weighs the evidence in making a determination of whether a minor is mature enough to handle a health care decision, he must find proof of this maturity by clear and convincing evidence.

*In re E.G.*, 133 Ill. 2d 98, 110-11, 549 N.E.2d 322, 327-28 (1989). *See Application of Long Island Jewish Med. Ctr.*, 147 Misc. 2d 724, 727, 557 N.Y.S.2d 239, 241-42 (Sup. Ct. 1990).

Thus, assuming, *arguendo*, that the mature minor exception was applicable in this jurisdiction, the burden of proof was on the child and respondent mother to establish maturity by clear and convincing evidence. The respondent and child have cited no authority that expert psychological or psychiatric testimony is a necessary condition to determine the child's competency or maturity to make medical decisions on her own behalf. Notably, the respondent mother and child did not ask for a psychiatric or psychological evaluation to address the child's level of maturity. Thus, this claim must be addressed under the standard of *State* v. *Golding*, 213 Conn. 233, 239 (1989).

The notion of "maturity" of a child is not an alien concept for most people. Parents are commonly in the position of having to assess their child's level of maturity to determine, for example, whether a child is mature enough to be left home alone or to be given the keys

to the family car. Parents make these sorts of judgments all the time, as well as, decisions about what is the best interests of their child.

*In re Kyara H.*, 147 Conn. App. 829, 847, *cert. denied*, 311 Conn. 923 (2014), the Appellate Court addressed whether due process required the trial court to, sua sponte, order a psychological evaluation prior to deciding whether termination of parental rights was in the child's best interests. *Kyara H* applied the balancing test of *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). "Under this test, [t]he three factors to be considered are (1) the private interest that will be affected by the state action, (2) the risk of an erroneous deprivation of such interest, given the existing procedures, and the value of any additional or alternate procedural safeguards, and (3) the government's interest, including the fiscal and administrative burdens attendant to increased or substitute procedural requirements.... Due process analysis requires balancing the government's interest in existing procedures against the risk of erroneous deprivation of a private interest inherent in those procedures." *In re Kyara H.*, supra, 147 Conn. App. at 848-49.

Although there is arguably a "private" interest in self determination of the child's medical care, she also has a "private" interest in surviving her treatable form of cancer. While there is no doubt that undergoing chemotherapy is a difficult experience for a seventeen year old or anyone else, so is the process of dying. The uncontroverted medical evidence established that without treatment, her illness will be fatal. With treatment, there is an excellent chance of a complete recovery.

Not having expert psychiatric or psychological testimony would not substantially increase the risk of erroneous determination by the trial court. The Court observed: "[O]ur courts have consistently eschewed the notion that judges lack the ability to weigh the

evidence and make correct best interests determinations in termination of parental rights cases. As our state's highest court has observed: 'Although we often consider the testimony of mental health experts ... such expert testimony is not a precondition of the court's own factual judgment as to the child's best interest.'" *In re Kyara H.*, supra, 147 Conn. App. at, 851-52, citing *In re Jeisean M.,* 270 Conn. 382, 398 (2004). *See In re Alexander T.*, 81 Conn. App. 668, 676, *cert. denied*, 268 Conn. 924 (2004) (expert testimony not required for the court to consider whether parent is unable or unwilling to benefit from the efforts of the department); see also *State* v. *Jacob*, 69 Conn. App. 666, 682 (2002) (trial court not bound by expert evidence). Just as judges can make an assessment of the best interests of a child so, too, can they make an assessment of the maturity of a child.

In this context, the state has a compelling interest to make the competency determination expeditiously. The case had been delayed due to the mother's history of foot dragging, missed appointments, and apparently willful disbelief of medical experts, and the child running away from home, and then, apparently under her mother's influence, refusing treatment. The uncontroverted opinion of her treating physician was that the child had a short window of opportunity to begin treatment. If treatment was again delayed, it would mean that the child would have to undergo radiation treatment in addition to chemotherapy, with the additional risk having other cancers, such a breast cancer, as the result. (Affidavit of Michael Isakoff, M.D. 12/16/2014 (App. A31-A33); Tr. 12/9/2014, at 7; App. A53.) Furthermore, it would be pure speculation to say that having a psychological or psychiatric evaluation would have altered the outcome of the hearing. Respondent and child are

"unable to demonstrate that a constitutional violation clearly exists and clearly deprived her of a fair trial." *In re Kyara H.*, *supra*, 147 Conn. App. at 855.

## THE CONNECTICUT CONSTITUTION DOES NOT REQUIRE THAT OUR COURTS PERMIT A MINOR TO REFUSE LIFE-SAVING MEDICAL TREATMENT AND THEREBY FACE A VERY LIKELY PROSPECT OF DEATH.

### A. Introduction.

The Appellants assert two state constitutional rights. First, they claim that a minor, in this case, Cassandra, has a state constitutional right to bodily integrity. (Joint Brief, 37.) Second, they claim that the two, together, have a right to family integrity. (Joint Brief, 37.) Their argument that the Connecticut Constitution enshrines these claimed rights in a manner that requires that our courts permit a minor such as Cassandra to refuse life-saving medical treatment and thereby face a very likely prospect of death lacks merit.

At the outset, it is important to note three things. First, the Appellants make two different state constitutional claims. These claims are distinct from each other – "bodily integrity" on the one hand and "family integrity" on the other – yet Appellants' state constitutional analysis makes little attempt to elaborate the distinction between the two. Rather, under the guise of a *State* v. *Geisler* analysis, they slide between discussion of authorities that purport to support one right and those that might support the other right and then assert that they have established both rights. In the end, the argument for each is insufficient, and their conjunction does not remedy their deficiencies.

Second, to the extent that the Appellants make a claim for due process rights based on the Connecticut Constitution, they fail to acknowledge that our state courts have already declared, more than once, that generally the due process provisions of the United States and Connecticut constitutions "have the same meaning and impose similar constitutional limitations." *In re Dodson*, 214 Conn. 344, 362 n.15 (1990); *see also, e.g., Terese B. v.*

*Commissioner of Children and Families*, 68 Conn. App. 223, 226 n.6 (2002) ("[w]ith regard to the relationship between the fourteenth amendment and article first, § 8, ... their prohibitions are the same and that they are given the same effect"); *In re Jennifer W.*, 75 Conn. App. 485, 493 n.6 (2003) (same). Although the entire point of *State* v. *Geisler*-based state constitutional analyses is to permit consideration of new state constitutional rights – and, certainly, this Court in *Dobson* did not suggest that separate state constitutional due process arguments are always foreclosed -- the declaration that this state's due process provisions provide greater rights protections than does the federal constitution's is certainly the exception. To overcome this existing understanding of this state's constitutional due process provisions, a party must provide more than generalized precedents that merely recount broadly phrased common law and federal constitutional principles. Here, appellants' argument is insufficient to justify departure from this state's existing interpretation of state constitutional due process provisions.

Third, Appellants' reliance on a claimed right to bodily integrity fails to recognize that to the extent that such a right supports the related right to make independent decisions regarding medical treatment, such independent decision making is generally recognized for adults only. In the few jurisdictions in which courts have recognized such independent decision making for a minor, to assert consent or refusal to medical treatment, she or he can do so only after having established sufficient maturity to be deemed capable of exercising such a right.[14] Of course, in this matter, Appellants have not established the

[14] It is also necessary, as a prerequisite, that the jurisdiction recognize the mature minor exception. See this brief, *supra*. As Appellants concede, Connecticut has not yet recognized this exception to the well-established rule that a minor cannot make independent medical decisions. In their state constitutional argument, at no point do they claim that the mature minor exception is something that this Court must, as a constitutional

necessary factual findings to invoke a mature minor exception. Regardless, the authorities that relate to adult (and mature minor) rights do not operate to mandate a state constitutional right that any minor can refuse life-saving medical treatment and thereby face a very likely prospect of death.

**B. Standard of Review.**

Appellants' state constitutional claims involve two separate review matters, both of which entail *de novo* analyses. First, the claims are unpreserved, and therefore Appellants can prevail only if they satisfy the requirements set forth in *State* v. *Golding*. Second, if this Court were to reach the merits of these claims, it would conduct the task of determining state constitutional meaning pursuant to *State* v. *Geisler*.

**The State Constitutional Claims Fail Because Appellants Cannot Satisfy The Requirements For Successful Review Set Forth In *State v. Golding*.**

Appellants are not entitled to review of their state constitutional claims because they have failed to preserve an adequate record for review or, alternatively, they cannot establish that any constitutional violation exists. Specifically, because there is no factual basis on which they can claim that Cassandra, a minor, is nevertheless sufficiently mature to invoke any alleged state constitutional right to refuse medical care, the record is inadequate to review their claim. *See, e.g., In re Azareon Y.*, 309 Conn. 626, 638 (2013) ("[U]nder the test in *Golding*, we must determine whether the [appellant] can prevail on his

---

matter, recognize. Given that they do not argue for a state constitutionally required mature minor exception, all that remains of their argument is a generalized claim that the right to bodily integrity permits any minor, regardless of decision making capacity, to decide whether to accept or reject lifesaving medical care. This is so untenable that, not surprisingly, none of the authorities that they cite supports such a claim. In the end, Appellants' general references to "bodily integrity," without distinction about how this right applies in the differing contexts of minors, purportedly mature minors, and adults, leaves their claim wanting.

[or her] claim. The first prong of *Golding* was designed to avoid remands for the purpose of supplementing the record." (Internal quotation marks omitted.)). At the very least, even if a substantive review of their claims led to recognition of their claimed state constitutional rights, they cannot establish, as a factual matter, that it is likely that there was indeed a violation of those rights. Analysis of the constitutional question is therefore academic and, accordingly, not warranted. *See id.*

**The Connecticut Constitution Does Not Require That Our Courts Permit A Minor To Refuse Life-Saving Medical Treatment And Instead Face A Very Likely Prospect Of Death.**

Even if this Court were to consider the state constitutional claims, Appellants' arguments in favor of new state constitutional rights lack merit. The Department responds to the *State v. Geisler* analysis in the format that the Appellants present in their brief.

**Text and History of the Connecticut Constitution.** The argument that Connecticut's state due process provisions, based not on firm text but on "suggestions" that "may" support a conclusion different from that dictated by a federal due process analysis; (Brief, 38); is in form so generalized that it resembles those which our courts have already rejected. *See, e.g.*, *In re Dodson*, 214 Conn. at 362 n.15. Appellants resort to history does not add substance to the text-based argument. And their reliance on colonial common law for claims about bodily integrity and family actually leaves Cassandra in a worse position, at least insofar as Appellants fail to offer any authority that the common law recognized a minor's right, independent of parental control, to make decisions regarding medical care. It is axiomatic among the common law's most basic principles that minors had no inherent independent decision making authority. Whatever Swift (and others) might have expressed

in centuries past about bodily integrity, nothing from that era of law can be interpreted to support the type of right that Appellants now demand.

**Holdings and Dicta of Connecticut Courts.** The argument based on Connecticut precedent further demonstrates the fundamental shortcomings in Appellants' state constitutional argument. They offer two case citations in support of a generalized family integrity right. (Joint Brief, 39-40 (citing *In re Alexander V.*, 223 Conn. 557 (1992), and *Roth* v. *Weston*, 259 Conn. 202 (2002)) They also then cite one other case in support of a generalized bodily integrity right. (Joint Brief, 40 (citing [*Vega*]) Although none of these involved the state constitution, they roll together the precedents into a claim that this Court should interpret the state constitution in a novel way. None of these cases supports the extraordinary claim that the Connecticut Constitution enshrines a right for a minor to refuse lifesaving medical care.

**Federal Precedent.** Connecticut already sufficiently recognizes federal precedent in its interpretations and application of the U.S. Constitution. Nothing in federal precedents supports the Appellants' claim here that our state constitution requires the recognition of more expansive rights.

**Sister-State Precedent.** The Department recognizes that other states have considered and adopted a mature minor exception to the general rule that minors may not exercise an independent right regarding medical decision-making. But, to the extent that such a rule has been adopted as a judicially created exception to existing common law principles, Appellants have given no reason why these sister state precedents entail the requirement for a state constitutional declaration in favor of such a right.

**Public Policy Considerations.** Public policy arguments, such as those that Appellants relate in their brief, add nothing to their claim that the state constitution must enshrine the right that they claim. Indeed, such a fluid, developing concept as "mature minor" ought not to be enshrined as a constitutional right. Such a right, once constitutionally recognized, would likely soon engender cases of conflict between purportedly mature minors and their respective parents – conflict that will invite litigation between child and parent about a seemingly endless array of decisions that we now entrust, with good reason, to adults. Putting the constitutional thumb on the side of children claiming "mature" status will operate as a great, disruptive weight and create more harm than would a more reasonable, judicially crafted and managed, common law exception.[15]

## CONCLUSION

The trial court's decision should be affirmed as it is legally correct and factually supported so that the minor child may continue to receive life- saving medical treatment.

[15] Policy concerns such as these suggest that any exception to common law principles concerning minor decision making ought to be left to the legislature. The point above is that, at the very least, even if this Court were to consider the merits of a judicial decision in favor of a "mature minor" right, such a decision ought to be based on the common law rather than the state constitution.

Respectfully submitted,

JOETTE KATZ,
COMMISSIONER OF THE
DEPARTMENT OF CHILDREN AND
FAMILIES

Petitioner-Appellee

GEORGE JEPSEN
ATTORNEY GENERAL

Benjamin Zivyon
Michael Besso
Rosemarie Weber
Assistant Attorneys General

BY: _____

John E. Tucker
Assistant Attorney General
Juris No. 414085
MacKenzie Hall
110 Sherman Street
Hartford, CT 06105
Tel. (860) 808-5480
Fax (860) 808-5595
E-mail: John.Tucker@ct.gov

## CERTIFICATION

I hereby certify that a copy of the foregoing complies with the requirements of Practice Book §§ 67-1 and 67-2, including (g), (1), (2), (i), and (j) and complies with all the provisions of Practice Book §§ 62-7, and pursuant to Practice Book §§ 67-1, 67-2 (i)(3), and 77-2, the names or other identifying information prohibited from disclosure have been redacted or have not been revealed in the brief or appendix, and the foregoing redacted brief with appendix is a true copy -- which has been delivered electronically to the Court prior to the actual paper filing with the Court (e-mail confirmation is with original signed appeal) – of that which was forwarded to counsel of record at their last known e-mail addresses and pursuant to Practice Book § 67-2 (l) was forwarded to the trial judges on this 2nd day of January 2015 in addition to being mailed, first-class, postage prepaid, to the following counsel in accordance with Practice Book §§ 10-12 and 62-7.

The Hon. Barbara Quinn
The Hon. Carl E. Taylor
Superior Court, Child Protection Session
One Court Street,
Middletown, CT 06457

Michael S. Taylor, Esq. -- **Counsel for Appellant-Respondent Mother**
James P. Sexton, Esq.
Taylor & Sexton, LLC
Juris No. 436427
P.O. Box 270139
West Hartford, Connecticut 06127
Tel. (860) 325-0073; Fax (860) 838-6801
mtaylor@taylorsexton.com
jsexton@taylorsexton.com

Edward Joy, Esq.
Juris No 424977
128 East Center Street
Manchester, Connecticut 06040
Tel. (860) 432-4065
ejoylaw@gmail.com

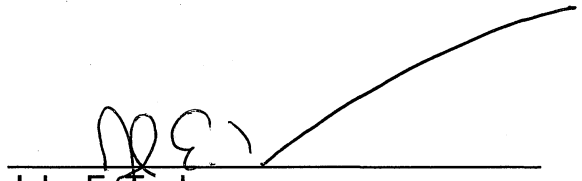
Joshua Michtom, Esq. -- **Counsel for the Child**
Office of the Public Defender
Child Protection Unit
Juris No. 433826
330 Main Street
Hartford, Connecticut 06106
Tel. (860) 566-1341; Fax (860) 566-1349
joshua.michtom@jud.ct.gov

Andreas Spoerk, Esq.
Juris No. 425714
P.O. Box 219
Avon, Connecticut 06001
aspoerk@sbcglobal.net

Jon Reducha, Esq. -- **Guardian ad Litem for the Child**
Juris No. 424342
35 Pearl Street, Suite 302
New Britain, Connecticut 06051
Tel. (860) 225-8447
jdarlaw@aol.com

Daniel J. Krisch, Esq.
Juris No. 26105
Halloran & Sage, LLP
225 Asylum Street
Hartford, CT 06103
Tel. (860) 522-6103; Fax (860) 548-0006
krisch@halloransage.com

Sandra Staub, Esq.
David McGuire, Esq.
Juris Nos. 432138 and 426587
American Civil Liberties Union
330 Main Street, First Floor
Hartford, CT 06106
Tel. (860) 523-9146; Fax (860) 586-8900
sstaub@acluct.org
dmcquire@acluct.org



John E. Tucker
Assistant Attorney General

**CERTIFICATION OF SUBMISSION OF**
**ELECTRONIC VERSION OF REDACTED BRIEF**

I hereby certify that a portable document format (pdf) copy of the foregoing redacted brief and appendix, is in compliance with all the provisions of Practice Book §§ 62-7, 67-1, and 67-2, including Practice Book § 67-2 (g), and is being electronically submitted to the Court, counsel of record at their last known e-mail addresses, and does not contain any personal identifying information prohibited from disclosure in compliance with the Practice Book; on this 2nd day of January 2015

Michael S. Taylor, Esq. -- **Counsel for Appellant-Respondent Mother**
James P. Sexton, Esq.
Taylor & Sexton, LLC
Juris No. 436427
P.O. Box 270139
West Hartford, Connecticut 06127
Tel. (860) 325-0073; Fax (860) 838-6801
mtaylor@taylorsexton.com
jsexton@taylorsexton.com

Edward Joy, Esq.
Juris No 424977
128 East Center Street
Manchester, Connecticut 06040
Tel. (860) 432-4065
ejoylaw@gmail.com

Joshua Michtom, Esq. -- **Counsel for the Child**
Office of the Public Defender
Child Protection Unit
Juris No. 433826
330 Main Street
Hartford, Connecticut 06106
Tel. (860) 566-1341; Fax (860) 566-1349
joshua.michtom@jud.ct.gov

Andreas Spoerk, Esq.
Juris No. 425714
P.O. Box 219
Avon, Connecticut 06001
aspoerk@sbcglobal.net

Jon Reducha, Esq. -- **Guardian ad Litem for the Child**
Juris No. 424342
35 Pearl Street, Suite 302
New Britain, Connecticut 06051
Tel. (860) 225-8447
jdarlaw@aol.com

Daniel J. Krisch, Esq.
Juris No. 26105
Halloran & Sage, LLP
225 Asylum Street
Hartford, CT 06103
Tel. (860) 522-6103; Fax (860) 548-0006
krisch@halloransage.com

Sandra Staub, Esq.
David McGuire, Esq.
Juris Nos. 432138 and 426587
American Civil Liberties Union
330 Main Street, First Floor
Hartford, CT 06106
Tel. (860) 523-9146; Fax (860) 586-8900
sstaub@acluct.org
dmcquire@acluct.org

John E. Tucker
Assistant Attorney General

**MAY CONTAIN INFORMATION PROTECTED BY ORDER OR STATUTE**

**REDACTED**

# SUPREME COURT

OF THE

# STATE OF CONNECTICUT

---

## S.C. 19426

**IN RE: CASSANDRA C.**

---

**APPENDIX**

---

# APPENDIX TABLE OF CONTENTS

NOS: T11-CP14-014681-A

SUPERIOR COURT FOR JUVENILE MATTERS

JUDICIAL DISTRICT OF TOLLAND, ELEVENTH JUVENILE DISTRICT

AT MIDDLETOWN, CHILD PROTECTION SESSION

NOVEMBER 14, 2014



IN THE INTERESTS OF CASSANDRA C., [1]

A PERSON UNDER THE AGE OF EIGHTEEN YEARS.

## ORDER

The Order of Temporary Custody (OTC) entered in reference to the above listed child on 10/31/14 in Superior Court for Juvenile Matters, 11th District, in Rockville, (SCJM) is hereby SUSTAINED.

The court hereby orders the following:

1. The court will vest the temporary custody and care of this child in the petitioner Department of Child and Families (DCF), subject to the following:

2. Cassandra (the child) will be placed back into the house and home of the respondent mother, Jacqueline F., once certain conditions have been complied with.

3. Prior to DCF returning the child to the home of the respondent mother, the respondent mother shall allow DCF to inspect the entirety of the premises of her residence and the child's residence, including all outbuildings.

4. The respondent mother shall allow DCF to enter the premises and inspect the

[1] Thus entitled in accordance with Connecticut (CGS) §§46b-124, and §46b-715 (b) and Practice Book §32a-7. The records and papers of this case shall be open for inspection only to persons having a proper interest therein and only upon order of the Superior Court.

premises whenever DCF wishes to do so. The respondent mother will cooperate with all DCF home visits, whether announced or unannounced, and will allow DCF unfettered access to all areas of her home.

5. The respondent mother shall allow DCF unfettered access to the child at all times.

6. The respondent mother will cooperate with the child's medical, psychological, psychiatric, or educational providers.

7. The respondent mother will consistently and timely meet and address the child's physical, educational, medical, or emotional needs, including, but not limited to, keeping the child's appointments with her medical, psychological, psychiatric, or educational providers. The respondent mother is responsible getting the child to all service providers in a prompt and timely manner. The respondent mother shall not miss any of the child's appointments with her service providers, or with DCF.

8. DCF is ordered to provide all necessary assistance to the respondent mother in order to assist her in keeping the child's appointments.

9. The respondent mother is to sign ALL releases for DCF to review all records from the child's medical, psychological, psychiatric, or educational providers. The releases will be signed no later that 48 hours after they are presented to The respondent mother.

10. All treatment for the child concerning her Hodgkin's Lymphoma and any other conditions reasonably related to the Hodgkin's Lymphoma will be treated at Connecticut Children's Medical Center.

11. Michael S. Isakoff, MD, shall serve as the child's treating physician and is empowered to refer that child to any other provider for additional treatment.

12. The respondent mother will not seek any medical second opinions concerning the child without the prior approval of the court.

13. Hemant K. Panchal, MD, shall continue to serve as the child's primary care physician.

14. The respondent mother shall maintain the child within the State of Connecticut during the duration of this case. The child shall not be removed from the home for more than 12 hours without the prior authorization of DCF or the Court in advance.

15. All further testing required for treatment and all treatment, including

chemotherapy, as recommended by Dr. Isakoff, shall commence within 72 hours of placement of the child in the respondent mother's home.

16. The failure of the respondent mother to comply with any aspect of these orders or of the specific steps shall constitute grounds for DCF to remove the child from the respondent mother's home, forthwith.

17. The failure of child to comply with any aspect of these orders or of the specific steps shall constitute grounds for DCF to remove the child from the respondent mother's home, forthwith.

18. DCF shall undertake all steps to expedite resolution of all issues with the child's health insurance.

19. The respondent mother will not to take any action designed to subvert, thwart, destabilize, undermine or endanger the child's placement.

20. The respondent mother will not to take any action designed to subvert, thwart, destabilize, undermine or endanger the child's medical care and/or treatment.

21. The respondent mother shall promptly review a copy of this order in its entirety with her counsel and will sign a copy of it, **as is.** The original signed copy shall be filed forthwith at SCJM.

22. The respondent mother shall promptly review a copy of the specific steps that the court has issued on this date in its entirety with her counsel and will sign a copy of it, **as is.** The original signed copy shall be filed forthwith at SCJM.

23. The child shall promptly review a copy of this order in its entirety with her counsel and will sign a copy of it, **as is.** The original signed copy shall be filed forthwith at the Office of the Clerk, SCJM.

24. The child shall not be placed in the home of the respondent mother until both the respondent mother and the child file their signed copies of this order at the Office of the Clerk, SCJM.

25. The child shall not be placed in the home of the respondent mother until the respondent mother files her signed copy of the specific steps at the Office of the Clerk, SCJM.

26. The court will instruct counsel for both the child and the respondent mother to thoroughly explain to their clients their obligations under this order.

27. The court will instruct counsel for both the child and the respondent mother to thoroughly explain to their clients their obligations under the disclosure rules

concerning juvenile proceedings.

28. DCF will keep the child's attorney and the guardian ad litem informed of the child's status & placement in a prompt and expeditious manner.

29. DCF shall provide any necessary information to the child's service providers.

30. The exhibits, records and transcriptions of this OTC hearing shall be preserved for use in future litigation in this case.

31. This is ordered returned to SCJM for all proceedings consistent with the relevant statutes.

32. This court orders that the issues relating to the respondent father and the OTC will be addressed at SCJM as soon as possible.

33. **The court will authorize DCF to release any necessary information to law enforcement agencies, if necessary, including a copy of this order and a copy of the respondent mother's specific steps.**

The Court

C. Taylor

C. Taylor

**SPECIFIC STEPS**
JD-JM-106 Rev. 1-11
C.G.S. §§ 46b-129(b), (d) & (j)
P.B. Sec. 33a-6

STATE OF CONNECTICUT
**SUPERIOR COURT**
JUVENILE MATTERS
*www.jud.ct.gov*

| Address of court | Docket number(s) |
|---|---|
| Superior Court for Juvenile Matters at **11th District, 25 School Street Rockville** | **T11-CP14-014681-A** |
| Name(s) of child(ren) **Cassandra C** | |

| Name of mother | Name of father |
|---|---|
| **Jacqueline F** | **Michael C** |

| Name of guardian *(if applicable)* | Current disposition |
|---|---|
| | |

| DCF worker | Phone |
|---|---|
| **Margaret Nardelli or other social worker to be designated at the pleasure of Commissioner, DCF** | **860-533-3600** |

| Name of CIP monitor | Phone | Name of Court Appointed Guardian Ad Litem | Phone |
|---|---|---|---|
| | | **Jon Reducha** | **860-225-8447** |

## Specific Steps

The Commissioner of the Department of Children and Families (DCF), the Petitioner in this case, and

| Name | Relationship |
|---|---|
| **Jacqueline F** | ☒ Mother ☐ Father ☐ |

(the Respondent), are instructed to comply with the following steps for the Respondent to safely retain or regain the custody of the child(ren) named above. (Connecticut General Statutes section 46b-129(j) and/or Practice Book section 33a-6.)

**The Respondent is ordered to:**

☒ Keep all appointments set by or with DCF. Cooperate with DCF home visits, announced or unannounced, and visits by the child(ren)'s court-appointed attorney and/or guardian ad litem.

☒ Let DCF, your attorney and the attorney for the child(ren) know where you and the children are at all times.

☒ Take part in counseling and make progress toward the identified treatment goals:
☒ Parenting ☒ Individual ☒ Family

Goals *(specify)*: **To cooperate in & support child's medical treatment. Other goals to be determined**

☒ Accept in-home support services referred by DCF and cooperate with them.

☐ Submit to a substance abuse evaluation and follow the recommendations about treatment, including inpatient treatment if necessary, aftercare and relapse prevention.

☐ Submit to random drug testing; the time and method of the testing will be up to DCF to decide.

☒ Not use illegal drugs or abuse alcohol or medicine.

☒ Cooperate with service providers recommended for parenting/individual/family counseling, in-home support services and/or substance abuse assessment/treatment:

**CCMC, Michael Isakoff, MD, Hermant Panchal, MD Other service providers to be determined**

☒ Cooperate with court ordered evaluations or testing.

☒ Sign releases allowing DCF to communicate with service providers to check on your attendance, cooperation and progress toward identified goals, and for use in future proceedings with this court. Sign the release within 30 days.

☒ Sign releases allowing your child's attorney and guardian ad litem to review your child's medical, psychological, psychiatric and/or educational records.

☐ Get and/or maintain adequate housing and a legal income.

☒ Immediately let DCF know about any changes in the make-up of the household to make sure that the change does not hurt the health and safety of the child(ren).

☐ Get and/or cooperate with a restraining/protective order and/or other appropriate safety plan approved by DCF to avoid more domestic violence incidents.

☐ Attend and complete an appropriate domestic violence program.

☒ Not get involved with the criminal justice system. Cooperate with the Office of Adult Probation or parole officer and follow your conditions of probation or parole.

CET

(continued)

☒ Take care of the child(ren)'s physical, educational, medical, or emotional needs, including keeping the child(ren)'s appointments with his/her/their medical, psychological, psychiatric, or educational providers.

☒ Cooperate with the child(ren)'s therapy.

☒ Make all necessary child-care arrangements to make sure the child(ren) is/are properly supervised and cared for by appropriate caretaker(s).

☒ Keep the child(ren) in the State of Connecticut while this case is going on unless you get permission from the DCF or the court to take them out of state. You must get permission first.

☐ Visit the child(ren) as often as DCF permits.

☒ Within thirty (30) days of this order, and at any time after that, tell DCF in writing the name, address, family relationship and birth date of any person(s) who you would like the department to investigate and consider as a placement resource for the child(ren).

☒ Tell DCF the names and addresses of the grandparents of the child(ren).

☒ Other: **Comply w/ any individual counseling as rec. by DCF & service providers. Comply with court order dated 11/14/14**

**DCF Is Ordered To:**

1. Take all necessary measures to ensure the child(ren)'s safety and well being.
2. Monitor the welfare of the child(ren) and the circumstances surrounding his/her/their care by the Respondent.
3. Provide case management services.
4. Develop periodic treatment/permanency plan and review it with the Respondent.
5. Refer the Respondent to appropriate services (see above) and, as otherwise needed, monitor his/her progress and compliance.
6. Provide respondent with written, dated notice of all referrals to service providers and retain copies of such notices for the court.
7. Implement reasonable recommendations made by service providers and/or evaluators in this matter, or obtain relief from the court.
8. Within thirty (30) days of the receipt of written notice by the respondent, complete the investigation and consideration of any person(s) whom the respondent has properly identified as a placement resource for the child(ren).
9. Within thirty (30) days, complete the investigation and assessment of any relative identified as a placement resource for the child.
10. Evaluate home of following person(s) as potential placement for child(ren):

11. In a Domestic Violence case, assist in developing, implementing and monitoring an appropriate safety plan.
12. Advise all parties of any changes in the child(ren)'s placement.
13. During the time DCF has custody of the child(ren), DCF shall keep the child(ren)'s attorney and/or guardian ad litem informed in writing of the child(ren)'s location, placement and contact information.
14. Provide releases to a child's attorney and guardian ad litem to review the child's medical, psychological, psychiatric and/or educational records if child is committed.

Other: **DCF will keep the child's attorney and the guardian ad litem informed of the child's status & placement in a prompt & expeditious manner. DCF shall undertake all steps to expedite resolution of all issues with the child's health insurance. DCF is ordered to provide all necessary assistance to the RM in order to assist her in keeping the child's appointments.**

**Authorized CIP Monitor Contacts:**

☐ DCF Worker ☐ Counselor or Clinic

☐ Foster Parent or Institution ☐ Child's/Youth's School ☐ Other: _____

## Approval And Order

☒ The court approves and orders the above steps as preliminary specific steps. This order shall remain in effect until the court orders final specific steps.

| Signed *(Judge)* | Date signed |
|---|---|
| C. Taylor | 11/14/2014 |

**Or**

☐ The court approves and orders the above steps as final specific steps that are part of the disposition of the above matter.

| Signed *(Judge)* | Date signed |
|---|---|
| | |

**I agree to cooperate with the conditions approved and ordered by the court and I understand that if I do not follow these steps the existing order or disposition may be changed. I understand that if I do not follow these specific steps it will increase the chance that a petition may be filed to terminate my parental rights permanently so that my child may be placed in adoption. I understand that I should contact my lawyer and/or DCF worker if I need help in reaching any of these steps.**

| Signed *(Respondent)* | Date signed |
|---|---|
| | |

**On behalf of DCF, as the Assistant Attorney General or Principal DCF Attorney representing the petitioner, I acknowledge that I have read these preliminary or final specific steps and DCF hereby agrees to cooperate with the above condition(s) approved and ordered by the court.**

| Signed *(Attorney)* | Date signed |
|---|---|
| | |

| | | |
|---|---|---|
| T11-CP14-014681 | : | Superior Court |
| S.C. 19426 | | |
| IN RE CASSANDRA C., | : | Judicial District of Middlesex |
| | : | Child Protection Session |
| | : | December 24, 2014 |

**EXPEDITED ARTICULATION**

*1. Background and Facts of this Case*

On November 12, 2014, after a contested hearing on the ex-parte order for temporary custody of Cassandra C., a seventeen year old with Stage Three Hodgkin's Lymphoma, temporary custody was vested in the Department of Children and Families, hereafter referred to as "DCF." Cassandra was nonetheless permitted to return home by court order, as both the child's mother and Cassandra herself promised that they would follow the recommended medical treatment, including chemotherapy. The acceptance of the treatment was a condition of her return home, while remaining in the custody of DCF. Only five days after Cassandra was returned home and on the second day of her first course of chemotherapy, she ran away from home and was unavailable for treatment.

On December 9, 2014, the matter was again before the court on an emergency basis. Despite the previous court orders, upon her return home, Cassandra refused treatment and her mother supported her decision to not treat her cancer. After a contested hearing, this court made certain findings and entered orders from the bench, reaffirming both Judge Taylor's previous order vesting custody and care of Cassandra in DCF and its right to make appropriate medical decisions for Cassandra. The court directed she not be returned home to

her mother, as the court did not find credible her mother's claim to be in support of chemotherapy for Cassandra.

2. *Motion for Articulation*

The matter is now on appeal before the Supreme Court. DCF has filed an expedited motion for articulation of this court's order, seeking clarification of that order with respect to those findings. It seeks articulation as to two questions:

(a) The extent to which the trial court credited the testimony of Dr. Isakoff in which Dr. Isakoff indicated that Cassandra did not have the capacity to make sound medical decisions concerning her cancer treatment, and

(b) To the extent that the child and the respondent mother have raised the "mature minor doctrine" on appeal, whether the trial court made a finding that the child was a mature minor?

The respondent mother and Cassandra have filed a motion in opposition, claiming that DCF is estopped from requesting such an articulation and asserting that the evidence before this court is inadequate to make such a determination. The court notes that it made brief findings on the record in this case on December 9, 2014, on the basis of an emergency motion. Those findings did not articulate all the court's conclusions, based on the evidence before it. It is not being asked to apply the doctrine, only to find facts from the evidence before it.

3. *Articulation*

In view of the shortness of time available and the serious matters at issue, the court grants the motion for articulation and denies the motion in opposition, based on the papers. The court hereby finds the following facts, based on the hearing held before it as well as the

transcript of the hearing held before Judge Taylor on November 12, 2014, which was a full exhibit at the hearing of December 9, 2014.

*Question A:*

The court finds credible the testimony of Dr. Isakoff, the treating oncologist. He stated that Cassandra did not have the capacity to make sound medical decisions concerning her cancer treatment. His testimony and demeanor in court demonstrated his caring and thoughtful concerns for this adolescent. He spoke of the life threatening nature of Cassandra's cancer and that she had no chance of survival without treatment. With treatment, it is a curable disease and her five year survival chances, based on clinical trials, are excellent. In view of all the information which had been provided to Cassandra, her apparent willingness to undergo treatment while secretly knowing she would not, the consequences of such behavior on the efficacy of future treatment, and the totality of all the facts she knew, Dr. Isakoff concluded that she did not have such capacity. And the court agrees and so finds.

The court observed Cassandra's demeanor at trial as well and saw how closely she followed her mother's testimony and hung on her every word. The DCF investigations worker testified on November 12, 2014 that Cassandra and her mother are close. She noted that Cassandra's mother did not appear to be in support of the chemotherapy and that Cassandra is concerned about going against what her mother would like to see happen.[1] On December 9, 2014, Cassandra's mother testified that Cassandra is a bright intelligent girl and that she can make her own decisions. She stated she believed it was Cassandra's right as a human being to decide whether to accept chemotherapy. She asserted her daughter was competent and old enough.

[1] Transcript, November 12, 2104 hearing, pages 27 and 28.

Such assertions are problematic, however, and without adequate support in the testimony and facts of this case. The doctors had reported to DCF that Cassandra's mother dominated most medical appointment conversations, during which Cassandra was withdrawn and not participating a great deal.[2] The record is replete with her mother's arguments with physicians about the diagnosis, her seeking three separate opinions about the diagnosis, attempting to change pediatricians and delaying follow-up appointments and needed treatment. The court concludes that Cassandra's mother has engaged in a passive refusal to follow reasonable medical advice for her mortally ill child. Her refusal brought about the physicians' referral to DCF in the first instance.

Cassandra is a child that has been homeschooled since the ninth grade and is totally dependent on her mother, her sole caretaker, as her father is not involved in her life. She has no siblings. She does not possess the necessary level of maturity or independence to make life and death decisions about her own medical care, as demonstrated both by her conduct and her behavior subsequent to the initial court order. The court finds, from the testimony and its observations of both the mother's and Cassandra's demeanor at trial, that Cassandra is overshadowed by the strong negative opinions her mother holds about her cancer diagnosis and treatment, including chemotherapy.

*Question B:*

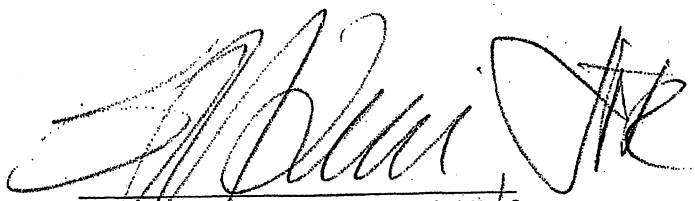
The second question concerning Cassandra's maturity is, in large part, answered by the court's findings above. The court has only heard brief testimony by the mother concerning Cassandra's maturity. The court gives greater weight to the testimony that she is not very mature. The physician's thoughtful assessment of her capacity, the court's own observations

[2] Transcript, November 12, 2014 hearing, pages 11 and 12.

of the parties and the witnesses, the observations of the DCF investigations worker and Cassandra's own actions all support the conclusion that she is an immature seventeen year old. She is not yet fully separated or independent of her mother. She engages in compulsive and risky actions and is unable or unwilling to speak her true mind to those in authority. While the court does not conclude that her mother has coerced her into her present position of refusing treatment, the court does find that her life circumstances make it difficult for her to hold opinions her mother does not share.

The court finds, from all the facts, that Cassandra is not a mature minor. She is as yet incapable of acting independently concerning her own life threatening medical condition. And time is running out for the recommended course of treatment to have a positive outcome for her future.

BY THE COURT



Barbara M. Quinn, Judge Trial Referee

NOTICE SENT: 12/24/14
BENJAMIN ZIVYON, A.A.G.
PAUL L. RUBIN
ROSENZWEIG, FAGAN, SHEEHAN & WATSON
ROSEMARIE T. WEBER, A.A.G.
JOHN E. TUCKER, A.A.G.
TAYLOR & SEXTON LLC
ANDREAS SPOERK
JOSHUA D. MITCHTOM, A.P.D.
HALLORAN & SAGE LLP
CHILD PROTECTION SESSION @ MIDDLETOWN
CP14 014681



er

Cancer and Blood Disorders Services
Division of Hematology and Oncology
*Connecticut Children's Specialty Group*
*Department of Pediatrics*
*University of Connecticut School of Medicine*
*282 Washington Street*
*Hartford, CT 06106*
*Phone: 860-545-9630* *Fax: 860-545-9622*

Donna M. Boruchov, MD
Eileen R. Gillan, MD
Michael S.Isakoff, MD
Kerry M. Moss, M.D.
Andrea D. Orsey, MD
Nehal S. Parikh, MD
Natalie Bezler, MD
Emily Peluso, APRN
Katherine Steven, APRN
Kathleen O'Leary, APRN
Christine Eaccarino, PRN
Sarah Matney, RN, BSN
Nurse Manager

In Re: Cassandra C

Date : October 30, 2014

## AFFIDAVIT

I, Michael Isakoff , physician at Connecticut Children's Medical Center in Hartford, Connecticut, am over the age of eighteen and understand and believe in the obligations of an oath. Being duly sworn, I do hereby depose and say that the following is the truth to the best of my knowledge and belief:

Child who is subject of this affidavit:

Cassandra C (name)
/97 (DOB)

Center ST

, CT 06 (address)

Jackie F (parent's name)

Center ST

CT 06 (parents address)

I am a physician board certified in pediatric hematology and oncology. I have 9 years of experience as an attending physician following my 3 years of post-doctoral fellowship training at Dana Farber Cancer Institute and Boston Children's Hospital. I am currently an Assistant Professor of Pediatrics for UConn Medical School and the co-Director of the Center for Cancer

and Blood Disorders at Connecticut Children's Medical Center. My expertise in the field of oncology is broad and includes the treatment of patients with Hodgkin's lymphoma.

Cassandra C was initially scheduled for a new patient consult in hematology/oncology on 9/4/14 but no showed to that appointment. Cassandra was rescheduled for an appointment on 9/9/14. My colleague, Eileen Gillan, saw Cassandra on this date. According to the medical records, Dr. Gillan recommended that Casandra have a biopsy of an enlarged lymph node.

Cassandra's mother consented and a biopsy was completed by Brendan Campbell on 9/12/14. The Pathology result confirmed a diagnosis of Classical Hodgkin's Lymphoma, nodular sclerosis subtype. Based on these imaging studies, Cassandra has at least stage III disease, with a possibility of stage IV. However, the staging evaluation was not complete. According to the medical record, Dr. Gillan called Cassandra's mother on 9/19/14 and informed her of the diagnosis and recommended that she come for follow-up to obtain further evaluations that would be needed for staging and to begin discussions regarding treatment. Cassandra's mother refused. Additional attempts by our office to schedule Cassandra for a PET scan via telephone calls were unsuccessful and mother refused to come in for the scan. At this point, Cassandra's stating evaluation remains incomplete.

Cassandra's mother eventually agreed to bring Cassandra in for a visit to see me. This visit was scheduled for 10/7/14. However, Cassandra's mother and Cassandra's uncle came to the visit without Cassandra. I did meet with Cassandra's mother and uncle to review the diagnosis and next steps that I recommended. We first reviewed the pathology diagnosis, CT scan results, and discussed my proposed plan for future staging evaluations and treatment. I explained to mom my recommendations for treatment; approximately 6 months of chemotherapy with an attempt to avoid radiation, if response was adequate. I recommended OEPA - COPDAC chemotherapy with PET evaluation after 2 cycles and elimination of radiation for those with a complete PET response. I strongly recommended to mom that Cassandra return within two weeks for port placement and to begin therapy. Cassandra's mother asked for one week to think about it and to obtain a second opinion. I informed mom that a second opinion was completely reasonably but expressed concerns about this delaying treatment further. I asked that she get back to me within two days (Thursday, 10/9) to discuss how she would like to proceed. I reiterated that the majority of patients with stage III or IV Hodgkin Lymphoma do not relapse with the therapy recommended, but that without therapy Cassandra will die of her disease.

Repeatedly throughout our meeting Cassandra's mother raised concerns and frustrations with other care givers and hospital processes. On multiple occasions I had to redirect her back to the conversation of Cassandra's care. I offered her the opportunity to discuss concerns about service at another time, reiterating that it was critical for us to discuss Cassandra's diagnosis and plan of care. My meeting with Cassandra's mother lasted for two hours.

Cassandra's mother did not contact our office in the time frame of two days that was requested. However, she did go to Bay State Medical Center to see Dr. Matthew Richardson. At this point I transferred Cassandra's case to Dr. Richardson as primary oncologist. It is my understanding that Cassandra no showed to several appointments and that Cassandra's mother continued to reject

scheduling attempts. As of today, Cassandra has still not completed her evaluations and has not started therapy.

Patients with Hodgkin's lymphoma that is stage III or IV are classified as High Risk. The prognosis for High Risk patients who receive treatment with chemotherapy and in some cases radiation therapy is very good. Research of patients with High Risk Hodgkin's lymphoma indicates that after 5-years approximately 85% of patients treated with current standard regimens are free of disease. Without treatment Hodgkin's lymphoma is universally fatal.

WHEREFORE, based on the aforementioned information and this affiant's medical expertise, believe this child is suffering from medical neglect, is in immediate physical danger, and that the conditions or circumstances surrounding the care of this child requires that custody be immediately assumed by a third party to safeguard the welfare of the child.

THE AFFIANT:

_____ (signature)

Michael Isakoff (name) 10-30-14

SUBSCRIBED AND SWORN TO before me on this 30 day of October, 2014.

_____ (signature of Notary Public) 10-30-14

6-30-2016 (my commission expires)

MILLY-JO ALICEA
NOTARY PUBLIC OF CONNECTICUT
My Commission Expires 6/30/2016

Connecticut Children's Specialty Group, Department of
Hematology/Oncology
282 Washington Street
Hartford, CT 06106-3322
DEPT: 860-545-9630
FAX: 860-545-9622

October 8, 2014

Hemant Panchal, MD
170 Hazard Avenue
Enfield CT 06082

Patient: **Cassandra L C**
MR Number: **0296846**
Date of Birth: **/1997**
Date of Visit: **10/7/2014**

Dear Dr. Panchal:

I saw the parent of Cassandra L C on 10/7/2014. Included below is the note regarding this visit.

Today, I had a meeting with Cassandra's mother and her uncle. Cassandra was not present for this meeting. I was accompanied by Christine Eaccarino APRN, Dr. Brendan Campbell, and a medical student.

The conversation began with mom sharing with me her frustration from her perspective that no one has explained what has been going on. She claimed that Dr. Gillan did not give her a clear diagnosis over the phone and claimed that she did not receive CT scan results. She raised her voice multiple times during the conversation, which I interpreted as her being angry about her perception that information was not shared in a timely manner. I explained that my primary concern is the care of Cassandra and that while I appreciated that mom had concerns about service, this was something that we would need to discuss at a separate time. I explained that for the time we had today it was critical to review the pathology diagnosis, CT scan results, plan for further staging evaluations, and general recommendations regarding therapy. Despite multiple attempts to review Cassandra's diagnosis and plan, mom brought the conversation back to frustrations with other doctors and her claims of delays.

However, with agreement from the uncle, Cassandra's mom did allow me to review information that I felt strongly needed to be imparted. I explained that she has been diagnosed with nodular sclerosing Hodgkin lymphoma and that there was not any question regarding this diagnosis. I explained that the timeline from biopsy to Dr. Gillan's call to tell her the diagnosis at about a week was not out of the ordinary considering the special staining and testing that is typically done on pathology samples. Mom was very concerned that she signed consent for a lymph node to be removed and the whole node was not removed. It was explained by Dr. Campbell and reiterated by me that during the procedure it was felt that enough tissue for

obtaining a diagnosis could be removed without risking a more complicated procedure around vasculature, for no additional benefit associated with removing the complete large lymph node. Mom rolled her eyes at this and questioned why he would not remove the whole thing and stated that this could have eliminated the need for chemo or change the chemo. I explained that this was incorrect and that removing enough tissue to make a diagnosis is all that is needed and further surgery would be inappropriate and unnecessary, only placing Cassandra at undue surgical risks. I explained that with nodular sclerosing Hodgkin's Lymphoma, patients require therapy to have a chance of survival; especially with stage III or IV disease. Surgery will not contribute to increased survival in this situation.

I explained that Cassandra appears to at least have stage III disease, but her imaging is limited and there are 2 indeterminate pulmonary abnormalities that could represent Hodgkin's, which would indicate stage IV. I also explained that to complete her full baseline testing, she will need a PET scan and CT that included abdomen and pelvis. In addition, given the month that has passed she should have a CT that includes the neck and chest also. Additionally, given the extent of adenopathy and high risk disease, she should have a bilateral bone marrow evaluation, which I recommended to be completed in the OR at the time of a port-a-cath placement, which I recommended for treatment.

As noted above mom repeatedly voiced her concern that delays were caused by different doctors in the hospital. I did not push the issue with mom, but I do note that physicians have reported to me that biopsy was recommended at the initial surgical consultation months ago and recommended at various points since then. In addition, Dr. Gillan called mom to give the path results and our office previously scheduled Cassandra for a PET/CT, but mom cancelled the appointments and told our office staff that the schedule did not work for her and she would not allow the imaging to be done. My impression is that the medical team has acted appropriately in making recommendations for evaluations, including performing an appropriate biopsy that has definitively demonstrated a pathologic diagnosis of Hodgkin Lymphoma. I attempted to again redirect mom that my focus was on Cassandra and that while I thought we could further address her concerns regarding timing at a separate later point, I did want to focus at this visit only on Cassandra's situation at present and my recommendation. Mom did note that she appreciated that I gave her a straightforward "black and white" answer regarding her diagnosis.

In addition, I have given mom my general recommendations regarding therapy, which I explained would include approximately 6 months of chemotherapy with an attempt to avoid radiation, if response was adequate. I recommended OEPA - COPDAC chemotherapy with PET evaluation after 2 cycles and elimination of radiation for those with a complete PET response. I have given a brief review of major therapy toxicities and goal of this particular regimen of attempting to decrease acute and chronic toxicity.

Finally, to coincide with mom's wish for things to be presented in a more 'black and white' manner vs sounding 'wishy - washy' I have given my strong recommendation that now that we have a final diagnosis that we move forward with completing evaluations and making plans to have a port inserted and start therapy within 2 weeks. I am not comfortable with further delays beyond that, especially with no further imaging in the last month and no clear understanding of Cassandra's current clinical status. Mom and Uncle asked about a second opinion and I told them that this would be completely reasonable but not at expense of completing evaluations and making plans for starting therapy. I offered to help in this process and that if

they identified a hospital that they would like this done we could facilitate this happening as quickly as possible.

I then told mom that I would like to schedule the imaging studies to move things along. However, she did not want this to happen yet and told me that she needed to think about things for the next week. I told her that although I understood that she could use more time, I felt that this would compromise my ability to begin therapy for Cassandra within the next two weeks and therefore I would need to know what her plans are and what she will agree to within the next two days. I again explained that my priority is the safety and medical management of Cassandra and that giving her the best chance of survival. I reiterated that the majority of patients with stage III or IV Hodgkin Lymphoma do not relapse with the therapy that I am recommending, but without therapy she will die of her disease. I also told her that even with therapy a minority of patients do relapse and do not survive, but that the therapy does give the best chance of surviving.

After mom repeated that she needed a week I again stated that although I recognized that this is what she wished, I was most concerned about Cassandra's disease and I would need her to inform me by Thursday of how she would like to proceed and if she will agree to scans being scheduled within the next week. Mom did not appear to like hearing this and informed me that she did not like being threatened, to which I told her I was not giving her a threat but reiterated that my priority was the health of her child and I would need to know her plans and what she was willing to do by Thursday so that Cassandra's evaluations could be completed and she could begin therapy.

The visit ended with mom again voicing her concern that doctors have previously not communicated well with her, including her claim that she was told that all of Cassandra's medical records would be waiting for her at today's visit, though she did report that she had not signed a release for medical records. I recommended that she go to the front desk upon departing the visit and staff would help her obtain the records. A follow up visit and scans will be planned pending hearing from mom later this week.

In total, I spent approximately 120 minutes meeting with mom and uncle.

Sincerely,

Michael S. Isakoff, MD

CC: Hemant Panchal, MD
170 Hazard Avenue
Enfield CT 06082
VIA Facsimile: 860-763-1398

Connecticut Children's Specialty Group, Department of
Hematology/Oncology
505 Farmington Ave
Farmington, CT 06032-1936
DEPT: 860-545-9630
FAX: 860-545-9622

October 17, 2014

F ,Jackie
CENTER ST
CT 06

Re: Cassandra L C

Dear Ms. F ,

I am writing to express my concern for your daughter Cassandra.

To briefly review the information discussed during our 10/7/14 meeting:

Cassandra has been diagnosed with nodular sclerosing Hodgkin Lymphoma. Based on her radiographic imaging that has been completed to this point, she has at least Stage III disease. In order to complete her full evaluations to assess how much lymphoma is present, how active it is at baseline, and where it has spread, Cassandra requires a CT scan and a PET scan.

In addition, in order to complete a full evaluation Cassandra would require a bone marrow evaluation. As we discussed, this would involve bilateral bone marrow aspirates and bone marrow biopsies of the iliac crests, which are at the back of the pelvis. This can be completed under sedation or general anesthesia.

As per our conversation on 10/7/14 I have recommended that Cassandra have a port-a-cath placed for administration of chemotherapy. I have explained and would like to reiterate here that a majority of patients with Hodgkin lymphoma can be cured of their disease with chemotherapy, though some do require radiation therapy in addition to chemotherapy. The role of surgery is primarily for diagnosis and will not contribute to her ability to be cured.

Despite improvements in therapy over the past 40 years, there are patients who do not respond to therapy or who relapse and die of their disease. This is true for the minority of patients.

Unfortunately, without treatment Cassandra will die of her disease.

I also understand that you do not wish to expose Cassandra to 'poisons'. Therefore, a balance between the side effects of therapy and effectiveness of therapy need to be balanced. We would like her to get the best treatment possible and to give her the best chance at cure while exposing her to a treatment regimen that does try to limit toxicity.

It is critical that Cassandra move toward the next step of evaluations and treatment as soon as possible. As I shared on 10/7, my recommendation is that Cassandra should start therapy in approximately 2 weeks, which would be by 10/21, and I had asked that you contact our office regarding our planning next steps by 10/9.

Although the timing will not be possible to start therapy by 10/21, I urge you to contact our office at 860-545-9630 to set up Cassandra's next visit so that plans can be placed into action as soon as possible. If you have transitioned Cassandra's care to another pediatric oncologist, please contact our office with this information so that we can complete a comprehensive transfer of care.

Sincerely,

Michael Isakoff, MD
Co-Director, Center for Cancer and Blood Disorders
Connecticut Children's Medical Center

Date: 11/3/2014

Dear Dr. Panchal:

I saw your patient Cassandra L C on 11/3/2014 for a follow-up visit regarding her diagnosis of Hodgkin's lymphoma. Included below are the progress notes from her visit.

Connecticut Children's Medical Center

**Cancer and Blood Disorders Services**
**Division of Hematology and Oncology**
*Connecticut Children's Specialty Group*

Patient Name: Cassandra L C
DOB: /1997
MRN: 0296846
Primary Care Provider: Hemant Panchal

**Progress Note**

**Date:** 11/4/2014

**Chief Complaint:** Hodgkin's lymphoma

**HPI:** 17 year old female with recently diagnosed Hodgkin's lymphoma. Biopsy on 9/12, family informed of diagnosis on 9/19. However, at initial refusal to obtain staging studies. Returned to clinic on 10/7 without Cassandra and I reviewed her diagnosis and recommended staging and starting therapy as per my prior note. Cassandra was then brought to Bay State Med Center for a 2nd opinion, where her diagnosis was confirmed and there was agreement with recommended staging and plan for port placement and treatment. Cassandra did have the PET scan which has been reported to me as having extensive disease, including diffuse marrow uptake, which is not definitive, but concerning for possible marrow involvement. However, further follow-up including initiation of therapy has not taken place. Cassandra is now under DCF custody and returns today for a discussion of her diagnosis, staging, and recommendations for further evaluations and treatment. She is accompanied by her mother, uncle, DCF supervisor, foster parent, and 2 other DCF workers. Cassandra reports currently feeling well. She does not report pain with her lymphadenopathy.

**ROS:** Review of Systems
Constitutional: Negative for fever, activity change, fatigue and unexpected weight change.
HENT: Negative for neck pain.
Eyes: Negative for visual disturbance.
Respiratory: Negative for shortness of breath and wheezing.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for nausea, abdominal pain and diarrhea.
Genitourinary: Negative for difficulty urinating.
Skin: Negative for rash.
**No pruritis**
Neurological: Negative for dizziness and headaches.
Hematological: Positive for adenopathy.

**Birth History:** No birth history on file.

**Past Medical History:**
Past Medical History Pertinent Negatives

| Diagnosis | Date Noted |
|---|---|
| • Prematurity, fetus 35-36 completed weeks of gestation | 9/12/14 |

Past Medical History

| Diagnosis | Date |
|---|---|
| • Lymphadenopathy<br>*Per CT scan-Extensive cervical, supraclavicular, mediastinal and retroperitoneal* | |

**Family History**: family history includes Anesthesia problems in her mother. There is no history of Bleeding disorder.

**Surgical History:**
No past surgical history pertinent negatives on file.
Past Surgical History

| Procedure | Date |
|---|---|
| • Lymph node biopsy | |

**Social History:**
History

Social History

| | |
|---|---|
| • Marital Status: | Single |
| Spouse Name: | N/A |
| Number of Children: | N/A |
| • Years of Education: | N/A |

Social History Main Topics

| | |
|---|---|
| • Smoking status: | Never Smoker |
| • Smokeless tobacco: | None |
| • Alcohol Use: | None |
| • Drug Use: | None |
| • Sexually Active: | None |

| Other Topics | Concern |
|---|---|
| • None | |

Social History Narrative
• None

**Medications:**
No current Epic-ordered outpatient prescriptions on file.

**Allergies:** Review of patient's allergies indicates no known allergies.

**Physical Exam:**
Blood pressure 126/83, pulse 109, temperature 37.1 °C (98.8 °F), temperature source Tympanic, resp. rate 20, height 163.8 cm (5' 4.49"), weight 82.2 kg (181 lb 3.5 oz), SpO2 100.00%.

Physical Exam
Constitutional: She appears well-developed. No distress.
HENT:
Head: Normocephalic.

Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Eyes: Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes.
Abdominal: Soft. She exhibits no distension and no mass. There is no tenderness.
Lymphadenopathy:
She has cervical adenopathy **(large adenopathy creating visual deformity of right neck. Multiple enlarged nodes palpable. Left neck also with multiple nodes. Supraclavicular region with bilateral adenopathy).**
Neurological: She is alert.
Skin: No rash noted. No erythema.
Psychiatric: Her behavior is normal.

**Assessment and Plan by Problem:**

Cassandra is a 17 y.o. female with Hodgkin's lymphoma. Based on staging studies completed thus far Cassandra appears to have at least stage III, but could have stage IV disease. I will need to view her PET scan and have recommended that she have a bone marrow evaluation to complete her staging. I have explained what a bone marrow would involve, but Cassandra does not want to have this procedure. I explained it would be standard of care and would complete the staging so that I can have the most clear discussions with them regarding risk of relapse/prognosis. However, if they refuse, I would presume that she is stage 4. The treatment that I would recommend for stage III and stage IV would be the same and therefore, treatment would not be effected by the lack of bone marrow.

I have strongly recommended a port-a-cath placement for treatment due to use of vesicant therapy and risk of extravasation with peripheral IV. I also have concerns about the ability to place a peripheral IV daily during the first 6 days of OEPA chemotherapy, which involves 6 days in a row of IV therapy during week 1. A PICC line could be considered, but has an increased infection risk and the catheter threads to the same place in the vein as a port, which is one of the concerns expressed by Cassandra and her mother. A port-a-cath carries the lowest infection risk and allows her the greatest freedom as it is embedded under the skin. I have told her that we may be able to try the peripheral IV, but only if she is willing to get a port-a-cath if that doesn't work.

I have recommended that they return in 2 days to review the chemotherapy plan that I recommend, which includes the OEPA-COPDAC regimen, aimed at reduction or elimination of radiation while also decreasing toxicity compared to historical regimens.

The family expressed interest in a third path opinion in Boston and I will plan to ask the path department to send to Boston Children's/DFCI to review. In general, I think it is reasonable to get a second opinion regarding treatment, but given the amount of delays to this point I am concerned about further delays to obtain further opinions. In addition, the family has expressed concern and doubt regarding the diagnosis, but have not questioned the treatment. Mom has asked about another biopsy as part of a second opinion and I have told her that this would be medically inappropriate as it would put her through a procedure that was not necessary, exposing her to risks without a benefit. I have explained that the biospy definitively shows Hodgkin lymphoma, her scans, including the report of PET scan are all consistent with Hodgkin lymphoma and any further biopsy, even if it was of normal tissue, would not negate the fact that a biopsy of an abnormal lymph node revealed a definitive diagnosis of Hodgkin lymphoma. I have also told her that there was nothing inconclusive about the biopsy and that although I understood her concern about mistakes in the medical field, it would not be possible to mistakenly diagnose Classical Hodgkin's Lymphoma with a nodular sclerosing subtype, given all of the special staining that was done on the sample. In addition, a second opinion has already agreed with the diagnosis. Nonetheless, I will be sending the specimen for review in Boston as noted above.

Although Cassandra does not have any 'B' symptoms I can not predict the timing of when her disease could

make her very sick and I have strongly recommended starting therapy as soon as possible, while she is still feeling well. I have explained that it is typical for patients without 'B' symptoms to feel well, but this does not negate the fact that these patients have Hodgkin's lymphoma.

I have re-iterated that without treatment she will die of the cancer. With treatment, the majority of patients are cured.

I spent over 50% of a 120 minute visit face to face with a patient, counseling and coordinating care of the above issues.

**Signed:** Michael S. Isakoff, MD

Sincerely,

Michael S. Isakoff, MD

CC: Hemant Panchal, MD
170 Hazard Avenue
Enfield CT 06082
VIA Facsimile: 860-763-1398

**Hemant K. Panchal MD**
**170 Hazard Ave**
**Enfield, Ct 06082**

October 30, 2014

Cassandra C has been a patient in this office since 3/17/1999. Initially seen at CCMC ER on 5/25/2014 for abd pain. Was seen by OBGYN Dr Bhagat on 5/27/2014. We had seen Cassandra initially on 5/28/2014 for c/o stomachaches, lower back pain and R lateral chest pain near ribs, a very large r anterior cervical gland tender to palpation was found at that time. At that time pt had positive strep test in office and placed on amoxicillin labs done with f/u in 2 days. Pt came back in on 6/2/2014 gland 60% improved and no stomach pain. Rechecked on 6/9/14 gland still swollen 70% improved rapid strep neg. Seen 6/19/2014 for follow up repeat labs ordered done on 6/20/2014. Seen at our PWC center on 6/21/2014 for PPD reading and mom stated at that time that gland had increased in size. Follow up in office 6/23/2014 with swollen neck, head pain and lethargy. Consult to ID CCMC via phone at that time with Dr Fader and was advised to try Zithromax and would see pt on 6/30/2014 at 830am. Pt seen by dr Fader on 7/1/2014 and CXR done advised at that time follow up q week. Apt on 7/15/2014 cancelled by mom with ID CCMC. Seen here on 7/17/2014 for follow up and repeat labs ordered. Follow up here 8/7/2014 follow up labs done 8/8/2014 Went in to see Dr Fader (ID CCMC) on 8/12/2014 CXR paratracheal nodes enlarged, us neck enlarged thyroid mass, went over to Dr Rader CCMC surgery dept and discussed biopsy of mass. Mom was not returning calls to set up appt. Seen by heme/onc at CCMC on 9/9/2014 they ordered CT neck, chest, abd, pelvis at that time Biopsy done on 9/12/2014. Child dx with Hodgkin Lymphoma at that time. Then seen by heme/onc on 10/7/2014 (without pt just mom and uncle and Dr Isakoff). Heme/onc sent letter to mom 10/17 encouraging mom to begin treatment. I had tried many times to call mom for follow up with specialist to begin treatment and had spoken with Dr Fader and Dr Isakoff. Mom did not return my calls and then came in on 10/22/14 to discuss issues with DCF and promised to get treatment and to follow-up with appts but just wanted to go to BMC for treatment and not CCMC. I had received a letter from BMC heme/onc dated 10/22/2014, Dr Richardson and obtained approval for procedures and care at BMC. Then Heme/onc at BMC was calling me to say mom was not answering phone to set up appts for treatments and procedures. When my nurse in the office verified what number they were calling they said 860-654-9707 which mom had told us the only number to use was 860-752-5339, we told hemeonc this and they said mom told them never to use 860-752-5339. This got us concerned and we felt we needed to try to get our patient help. We did reach mom on 10/24/2014 and advised mom that we were letting DCF know that she is following plan and that we would help her get child seen, she stated that she would want to have some labs done that she had read about. On 10/27/2014 we called mom and Left her message to call us back to bring child in on 10/28/2014 for eval. Mom did not call back. She did come in with child on 10/28/2014 to obtain medical records and to transfer care to another MD. She would not tell us where she was bringing child for care and stated she had talked to the state and that she did not have to tell us anything. We asked her if she wanted us to check out Cassandra and she said no that she just wanted to get the medical records. We are very concerned with the fact that she is not getting treatment yet, not retuning calls and mom does not believe the diagnosis that the child has and is delaying treatment. Based on her Pet scan results, seeing the pt but not being able to exam her at this point we feel that she would benefit by immediate medical evaluation and intervention.

Hemant K. Panchal MD 10/30/14

Date Commission Expires: 9/30/2018
Subscribed and Sworn to me, a Notary Public in and for County of Hartford And State of Connecticut this 30th day of October, 2014

Notary Public Kailee Geo

DCF

# DEPARTMENT of CHILDREN and FAMILIES

*Making a Difference for Children, Families and Communities*

Joette Katz
Commissioner

Dannel P. Malloy
Governor

In re: Cassandra C DOB: /97

Date: October 30, 2014

I, Kimberly Kanaitis, am a registered nurse working for the Department of Children and Families as a Clinical Nurse Coordinator at 364 West Middle Turnpike Manchester, Connecticut. I am over the age of eighteen and understand and believe in the obligation of an oath. Being duly sworn, I do hereby depose and say that the following is the truth to the best of my knowledge and belief:

1. I was asked to consult on this case during the department's investigation due to Cassandra's diagnosis of Hodgkin's Disease. I have been assisting the department in information gathering and assessing the severity of Cassandra's diagnosis.
2. On 10/7/14, I spoke to Connecticut Children's Medical Center (CCMC) Infectious disease physician Dr. Feder. Dr. Feder reported Cassandra was diagnosed with Hodgkin's lymphoma a few weeks ago. Per Dr. Feder, the diagnosis came as a result of a needle biopsy and then confirmed with an open biopsy sample. He reports the next step was a complete hematology consult to develop a medical treatment plan. Per Dr. Feder, Cassandra will not survive with out medical intervention and he had concerns Ms. F , Cassandra's mother is not engaged in treatment. It is unclear if this denial is on Ms. F 's part due to Cassandra clinically presenting well at this time. Dr. Feder reports time is of the essence and delaying treatment can potentially complicate her medical treatment plan and overall prognosis.
3. Dr. Feder reported a PET Scan was ordered, but as of 10/7/14 it has not been completed.
4. Dr. Feder reports Ms. F will not commit to a treatment plan meeting to discuss next steps that include further testing to determine the stage of the cancer. He reports Ms. F uses delay tactics such as refusing types of testing, rescheduling appointments, requests for medical records, and comments that she is pursuing a second opinion. Dr. Feder reports this can be discussed and negotiated if Ms. F would agree to a treatment plan meeting.
5. Dr. Feder reports the diagnosis of Hodgkin's Disease makes Cassandra a priority within the medical community. He reports he has offered to refer Cassandra to either Yale or Boston for another opinion. He reports it takes a phone call from one physician to another and an immediate appointment can be secured. Dr. Feder reports feeling Ms. F is the only voice driving Cassandra's care and he would like Cassandra's input. Dr. Feder expressed frustration stating this process started in July 2014. He reports it takes Ms. F a month to follow up or through on any medical recommendations.

6. Dr. Feder reports Cassandra's initial biopsy appointment was delayed due to Ms. F canceling the appointment.
7. Dr. Feder reports CCMC Oncologist/Hematologist Dr. Guillan made numerous attempts at getting Ms. F to come into the office to review the biopsy results. Ms. F either refused or would reschedule appointments. Dr. Feder reports it got to the point that Dr. Guillan was forced to call Ms. F and give her the diagnosis over the phone. Per Dr. Feder, this is not typical, but due to Ms. F 's delaying tactics; she needed to be made aware of the diagnosis, so next steps could occur.
8. Dr. Feder reported he is no longer overseeing Cassandra's care due to the Hodgkin's diagnosis. He reports Cassandra requires a hematology and oncology physician.
9. Dr. Feder reports remaining involved to this point because of his relationship with Ms. F and he was hopeful Ms. F would understand the urgency in starting treatment. Dr. Feder reports as of last week, Ms. F is longer returning his calls
10. On 10/28/14, I participated in a phone conference with Oncologist Dr. Richardson from Baystate Hospital in Massachusetts. He reported based on the Pet Scan done on 10/23/14, Cassandra has extensive stage 3 lymphoma in her neck lymph nodes, chest and abdomen. The Pet Scan was originally scheduled for 10/21/14. Ms. F cancelled this. Ms. F did not attend the scheduled CT Scan appointment on 10/20/14. It should be noted these appointments were made by Dr. Richardson because Ms. F did not follow through in scheduling them.
11. Dr. Richardson reports needing a bone marrow biopsy to finalize the cancer staging, reporting Cassandra may have stage 4 cancer. He reports a liver and tonsil biopsy may now be medically indicated, but until he has the bone marrow biopsy, he cannot confirm this. He also is need of a complete bloodwork up.
12. Dr. Richardson reports he had hoped to complete this testing by 10/31/14, so that chemotherapy could be initiated no later than next week.
13. Dr. Richardson reports it has been approximately 8 weeks since the initial biopsy was completed, which puts Cassandra at higher risk for additional medical complications such as tumor lysis (an oncologic emergency caused by the tumor rupture).
14. Dr. Richardson reports typical cancer treatment from confirmed biopsy diagnosis until the start of chemotherapy is 23 days. Cassandra has exceeded this time frame.
15. Dr. Richardson reports prognosis is contingent on the bone marrow biopsy and provides percentage estimates of 80's for stage 3 and 75 for stage 4. Based on these percentages, it is my professional opinion, Cassandra would have a higher survival rate if testing and treatment was initiated at the time of the biopsy results.

16. Dr. Richardson reports Cassandra's cancer treatment would be better served in Connecticut due to the length of time out of state insurance authorization takes and it provides Cassandra with immediate access to medical care.
17. I have not been able to obtain any medical history on Cassandra due to Ms. F 's refusal to sign a release of information.
18. On 10/30/14, I spoke to pediatrician Dr. Panchal and his nurse Joanne regarding their 10/28/14 careline report. Joanne reports Ms. F came to their office requesting copies of Cassandra's medical record because she was changing pediatricians. Joanne reported Cassandra presented as "very white, not pale, white". She reported Cassandra was teary eyed. Per Joanne, Dr. Panchal came out and offered to assess Cassandra and Ms. F refused. Joanne stated Cassandra has not had any blood work since August 2014 and this was needed to assess Cassandra's current health status. This was explained to Ms. F . Joanne reports she offered to share the results of the Pet Scan and Ms. F refused stating she only came into request Cassandra's medical records.

It is my professional opinion that the Ms. F 's lack of medical follow up may contribute to Cassandra's prognosis and overall survival rate. Ms. F 's lack of compliance to comply with the medical plan of care is not in Cassandra's best interest.

Given these factors, allowing Cassandra to remain in Ms. F 's care will be insufficient to protect her from receiving adequate medical care for a potentially life threatening disease that is medically treatable. Under these circumstances, it impedes DCF and the medical provider's ability to ensure Cassandra's medical health and treatment goals are obtained.

WHEREFORE, there is reasonable cause to believe that based on the aforementioned information Cassandra's health, safety, and medical care will be maximized if Cassandra remains in care with DCF.

Sincerely,

Kimberly Kanaitis MSN, RN
Clinical Nurse Coordinator
Department of Children and Families

Subscribed and sworn to before me this 30th day of October, 2014

Kimberly Gable
Notary Public

Kimberly Gable
Notary Public
My Commission Expires 8/31/2017
Expiration Date

10/30/2014

Dear Sir or Ms.:

This letter is to clarify staging of Hodgkin lymphoma and Casandra's staging to date.

Very generally, staging is based on the number of lymph node groups involved, whether the groups are on one side of the diaphragm or both sides, and whether the lymphoma has spread to other organs (for example, to lung, liver, bone marrow).

**Stage I** - Involvement of a single lymph node region (for example, neck nodes, arm pit nodes, or lymph nodes inside the chest)

**Stage II** - Involvement of two or more lymph node regions on the same side of the diaphragm (for example, neck nodes AND nodes inside the chest)

**Stage III** - Involvement of lymph node regions on both sides of the diaphragm (for example, neck nodes AND lymph nodes in the abdomen)

**Stage IV** - Diffuse or disseminated involvement of one or more extranodal organs (for example Hodgkin lymphoma is found in the bone marrow when the marrow is biopsied)

In addition, the presence, or absence, of certain symptoms (called "B" symptoms) is associated with outcome. These symptoms are unexplained fever, night sweats, and weight loss. The absence of these symptoms is designated "A" and the presence of one or more is called "B".

Based on the information that I have, Cassandra is at least a stage IIIA (involvement with lymph nodes above and below the diaphragm, no report of "B" symptoms as of 10/14/14). She has not yet had bone marrow biopsies. A "PET" scan (a type of x-ray used in the staging of lymphoma) suggested abnormalities in her bone marrow that could be consistent with Hodgkin lymphoma in the bone marrow. Biopsies are needed to further evaluate this. Additionally, there is an appearance of her liver on her scan that may be consistent with lymphoma in the liver.

Sincerely,

Matthew Richardson, M.D.

ROBERT I. SCALZO
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
May 14, 2015

* Final Report *

| | |
|---|---|
| Result type: | Hematology Oncology Office Note |
| Result date: | 29 October 2014 12:21 |
| Result status: | Auth (Verified) |
| Result title: | Office Note |
| Performed by: | Richardson MD, Matthew on 29 October 2014 12:21 |
| Verified by: | Richardson MD, Matthew on 30 October 2014 12:00 |
| Encounter info: | 833056249, CTR CA CARE, Recurring OP, 10/8/2014 - |
| Contributor system: | NUANCE |

## * Final Report *

**Office Note (Verified)**

OFFICE NOTE

DATE:10/29/2014

Dear Sir or Miss:

I am a pediatric oncologist involved in the care of Cassandra C r (DOB 0 /97). I was asked to see her for a second opinion regarding a diagnosis of Hodgkin Lymphoma, a type of cancer. I took a history and performed a physical exam on Tuesday 10/14/14. I reviewed CAT scans and biopsy samples within the next 48 hours. I agree with the diagnosis of Hodgkin's lymphoma and the previous medical center's recommendations to complete staging (determining the extent of the cancer) and to start treatment expediently.

Cassandra's diagnosis is Hodgkin lymphoma, a type of cancer found in lymph nodes, but capable of spreading to other parts of the body. It is fatal if untreated. The chance of survival is related, in part, to the stage of the disease (how many lymph node groups are involved and has it spread to parts of the body other than lymph nodes). The lowest stage is stage IA; the highest stage is stage IVB. More than six weeks from the date of her biopsy, Cassandra has not completed her staging, thus I cannot say precisely what stage she has. From the information that we do have, she is at least stage IIIA. In order to complete the staging, she would need to have biopsies of her bone marrow and possibly a liver

there was either no answering machine and no one picked up or I left messages discussing possible complications if lymphoma progressed and the need to call me back. I called again on 10/19/14 but no one answered the number I dialed. I called twice on 10/20/14 to again review my second opinion and the need to complete staging. Cassandra's mother ultimately called me back on Monday 10/20/14. I reviewed my opinion that Cassandra indeed has Hodgkin lymphoma. I reviewed the sense of urgency to get staging and treatment done and possible complications if the cancer continued to progress. At that time, she had still not decided if she wished me to be the treating physician. Ultimately on Wednesday, 10/22/14, she called and indicated that she wanted me to be Cassandra's treating physician. On Thursday, 10/23/14, I left a message on her home phone to review the need to complete staging and start treatment; I reviewed that a significant amount of time had elapsed from the time of biopsy until now. I let her know that I could be available any time Tuesday through Friday of next week 9:30 to 3:00. I reviewed that waiting this long could be considered negligence/neglect and was getting outside the standard of care. I gave her the number for the surgery office to schedule port placement. Cassandra did get part of her staging done with a "PET-CT" scan (a type of x-ray) on Thursday 10/23/14. I attempted to call the family 4 times over the weekend (10/25-26) to review the scan results and the seriousness of them but each time there was no answer and no answering machine. I attempted to call them at least twice on Monday, 10/27/14 (using 2 different numbers), but got no answer on 1 phone number and an answering machine in another. I left a message to call me and that I could see her in the office anytime Tuesday through Friday 9:30 to 3:00.

Today, 10/30/14, Cassandra's mother called. I spoke with her. She relayed that she was moving forward with someone else to oversee Cassandra's care. I asked whom I should contact about the case but she said that she would pick up records. I re-iterated the importance of completing staging and starting treatment. She acknowledged that she was aware of the pre-treatment tests that were scheduled (heart and lung function tests standardly done before certain chemotherapy) but that she was not following through with them because she was moving forward with another doctor. I asked if she had time to discuss her scan but she said that she did not.

I am very concerned about the delays in Cassandra's treatment and feel that her health and chance of cure are being significantly compromised.

Lastly, if treatment needs to be mandated by the courts and overseen by DCF, then it is my recommendation that she receive treatment in her home state of Connecticut. She currently has

In Re: Cassandra C

Date : December 16, 2014

## AFFIDAVIT

I, Michael Isakoff, MD, co-director of the Center for Cancer and Blood Disorders at Connecticut Children's Medical Center in Hartford, Connecticut, am over the age of eighteen and understand and believe in the obligations of an oath. Being duly sworn, I do hereby depose and say that the following is the truth to the best of my knowledge and belief:

Child who is subject of this affidavit:

Cassandra C r

, 1997

Center Street, , CT, 06

---

Jackie F , mother

Center Street, , CT, 06

I am a physician board certified in pediatric hematology and oncology. I have 9 years of experience as an attending physician following my 3 years of post-doctoral fellowship training at Dana Farber Cancer Institute and Boston Children's Hospital. I am currently an Assistant Professor of Pediatrics for UConn Medical School and the co-Director of the Center for Cancer and Blood Disorders at Connecticut Children's Medical Center. My expertise in the field of oncology is broad and includes the treatment of patients with Hodgkin's lymphoma.

Cassandra C has been diagnosed with Advanced stage Hodgkin's lymphoma, Stage 3 or 4. Cassandra could not be definitively staged due to refusal of a bone marrow evaluation. I have estimated that patients with her stage of disease are cured in approximately 85% of cases.

Cassandra's mother gave written consent and Cassandra gave written assent to proceed with chemotherapy that I had outlined and began therapy on 11/17/15 as per the OEPA-COPDAC chemotherapy protocol. Copies of the consent document that outlined the planned therapy were provided to Cassandra and her mother.

Cassandra received day 1 and 2 of chemotherapy, but refused further therapy, which she later told me was her intention from the outset, but had agreed to start in order to be allowed back home with mom.

Cassandra has not received therapy beyond day 1 doxorubicin, vincristine, and prednisone, and day 2 etoposide and prednisone. Upon examination at admission she was noted to have cervical adenopathy; though I felt that her right neck node was a bit smaller and softer, consistent with response to treatment. Additionally, Xray imaging at admission was consistent with decrease of medastinal disease consistent with response.

On 12/15 in the afternoon I met with DCF who informed me and the medical team that they are making the decision that Cassandra will proceed with chemotherapy and port placement. I have explained to DCF and then met briefly with Cassandra's attorney and appellate lawyer to explain again that my goal is to give Cassandra the best chance of cure while minimizing toxicity. One of my goals would be to avoid radiation therapy. In the GPOH study of OEPA-CAPDAC, patients who received 2 courses of OEPA (given over 28 days) and had a complete metabolic response by PET imaging did not receive Radiation therapy. However, those with residual PET activity did require radiation. In Cassandra's case she only received day 1 and 2 of OEPA course 1. However, in an attempt to give her a chance to avoid radiation, I have recommended that we just skip the missed days, rather than repeating, and continue along the treatment plan, which would include starting the second course of OEPA at day 28. 12/15/14 is Day 28 and therefore would be ideal to start. However, I felt that a delay of starting OEPA course 2 for up to a week would be within an acceptable range, but beyond that would fall outside of acceptable and the treatment would fall outside of that intended by the protocol. Therefore, deviation beyond 7 days of a delay, thus beyond 12/22/14 from when due for course 2 of OEPA would lead to a requirement for radiation therapy.

In addition, I have explained and re-iterated to DCF and lawyers that her partial treatment is very concerning for the risk of setting her up for resistant disease if she does not continue along the treatment plan. There are unknowns that can not be predicted, but exposure to a treatment and allowance of disease to grow again, increases the risk that Hodgkin lymphoma cells will grow which are resistant to the agents received, including doxorubicin, prednisone, vincristine, and etoposide, which are all standard agents used in this disease.

I have explained to Cassandra that my goal is to give her the best chance at cure possible and that I understand that she has concerns about the toxicity of therapy. I have again tried to reassure her that while there are risks that chemotherapy carries, the serious risks are low. Certainly, risks such as hair loss are very high, but cardiac toxicity would be very low, I estimate at less than 1% for this therapy especially given that we gave her a cardiac protectant and would for other doses too . I re-enforced that while I felt it was the right thing for her to receive treatment that I would not be making the decision to force her to undergo therapy. I reminded her that most patients in this situation are cured and

that the risk of serious life threatening toxicity from the treatment was very low. Without treatment Hodgkin's lymphoma is universally fatal.

WHEREFORE, based on the aforementioned information and this affiant's medical expertise, believe this child is suffering from serious physical injury and/or illness, is in immediate physical danger, and that the conditions or circumstances surrounding the care of this child requires that interventions be immediately assumed to safeguard the welfare of the child.

THE AFFIANT:

_____ (signature)

Michael Isakoff, MD

SUBSCRIBED AND SWORN TO before me on this 16 day of December 2014.

_____ (signature of Notary Public)

6-30-2016 (my commission expires)

MILLY-JO ALICEA
NOTARY PUBLIC OF CONNECTICUT
My Commission Expires 6/30/2016

Connecticut Children's Medical Center

**Cancer and Blood Disorders Services**
**Division of Hematology and Oncology**
*Connecticut Children's Specialty Group*

Patient Name: Cassandra L C
DOB: /1997
MRN: 0296846
Primary Care Provider: Hemant Panchal, MD

**Progress Note**

**Date:** 12/15/2014

**Chief Complaint:** 17 year old female with Hodkgin's Lymphoma admitted for psychiatric evaluation and Hodgkin's Lymphoma care

**HPI:** Cassandra continues to report no overnight issues. She is being evaluated by the psychiatry team. Has been cooperative with staff. The plan is to insert a CVL and start therapy upon guidance of psychiatry and DFC after conversation with Cassandra.

**ROS:** Review of Systems
Constitutional: Negative for fever and activity change.
Respiratory: Negative for cough and shortness of breath.
Genitourinary: Negative for flank pain.
Musculoskeletal: Negative for back pain, arthralgias and gait problem.
Hematological: Negative for adenopathy. Does not bruise/bleed easily.
Psychiatric/Behavioral: Negative for behavioral problems.

**Birth History:** No birth history on file.

**Past Medical History:**

**Past Medical History Pertinent Negatives**

| Diagnosis | Date Noted |
|---|---|
| • Prematurity, fetus 35-36 completed weeks of gestation | 9/12/14 |
| • Allergy, unspecified not elsewhere classified | 12/9/14 |
| • Immune myopathy | 12/9/14 |

**Past Medical History**

| Diagnosis | Date |
|---|---|
| • Lymphadenopathy<br>*Per CT scan-Extensive cervical, supraclavicular, mediastinal and retroperitoneal* | |
| • Other malignant neoplasm without specification of site | |

**Family History**: family history includes Anesthesia problems in her mother. There is no history of Bleeding disorder.

**Surgical History:**
No past surgical history pertinent negatives on file.
Past Surgical History

| Procedure | Date |
|---|---|
| • Lymph node biopsy | |

**Social History**:
History

Social History

| | |
|---|---|
| • Marital Status: | Single |
| Spouse Name: | N/A |
| Number of Children: | N/A |
| • Years of Education: | N/A |

Social History Main Topics

| | |
|---|---|
| • Smoking status: | Never Smoker |
| • Smokeless tobacco: | None |
| • Alcohol Use: | No |
| • Drug Use: | No |
| • Sexually Active: | None |

| Other Topics | Concern |
|---|---|
| • None | |

Social History Narrative
• None

**Medications**:
No current Epic-ordered facility-administered medications on file.

No current Epic-ordered outpatient prescriptions on file.

**Allergies**: Review of patient's allergies indicates no known allergies.

**Physical Exam:**
Blood pressure 115/62, pulse 82, temperature 37.1 °C (98.8 °F), temperature source Temporal, resp. rate 16, height 164.6 cm (5' 4.8"), weight 82.1 kg (181 lb), SpO2 100.00%.

Physical Exam
Constitutional: She appears well-developed and well-nourished. She is cooperative.
HENT:
Head: Atraumatic. Hair is abnormal **(thinning)**.
Mouth/Throat: Mucous membranes are normal. No oropharyngeal exudate or posterior oropharyngeal erythema.
Neck: Neck supple.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no splenomegaly or hepatomegaly. There is no tenderness.
Musculoskeletal: Normal range of motion.
Lymphadenopathy:
She has no cervical adenopathy.

Right: Supraclavicular adenopathy present.
Left: Supraclavicular adenopathy present.
Neurological: She is alert. She has normal strength and normal reflexes.
Skin: Skin is warm and dry. No rash noted.
Psychiatric: She has a normal mood and affect.

**Assessment and Plan by Problem:**
Cassandra is a 17 y.o. female with Hodgkin's lymphoma admitted for psychiatric assistance surrounding her refusal of therapy. She has continued to do well, under DCF care with parental visitation. No new medical issues. She remains without a fever or SOB. Cassandra will remain inpatient with 1:1 supervision due to high flight risk in hopes of initiating chemotherapy next week.

**Signed**: Nehal S. Parikh, MD

Addendum:
On 12/15 in the afternoon I met with DCF who informed me and the medical team that they are making the decision that Cassandra will proceed with chemotherapy and port placement. I have explained to DCF and then met briefly with Cassandra's attorney and appellate lawyer to explain again that the goal is to give Cassandra the best chance of cure while minimizing toxicity. One of my goals would be to avoid radiation therapy. In the GPOH study of OEPA-CAPDAC, patients who received 2 courses of OEPA (given over 28 days) and had a complete metabolic response by PET imaging did not receive Radiation therapy. However, those with residual PET activity did require radiation. In Cassandra's case she only received day 1 and 2 of OEPA course 1. However, in an attempt to give her a chance to avoid radiation, I have recommended that we just skip the missed days, rather than repeating, and continue along the treatment plan, which would include starting the second course of OEPA at day 28. 12/15/14 is Day 28 and therefore would be ideal to start. However, I felt that a delay of starting OEPA course 2 for up to a week would be within an acceptable range, but beyond that would fall outside of acceptable and the treatment would fall outside of that intended by the protocol. Therefore, deviation beyond 7 days of a delay, thus beyond 12/22/14 from when due for course 2 of OEPA would lead to a requirement for radiation therapy. In addition, I have explained and re-iterated to DCF and lawyers that her partial treatment is very concerning for the risk of setting her up for resistant disease if she does not continue along the treatment plan. There are unknowns that can not be predicted, but exposure to a treatment and allowance of disease to grow again, increases the risk that Hodgkin lymphoma cells will grow that are resistant to the agents received, including doxorubicin, prednisone, vincristine, and etoposide, which are all standard agents used in this disease.

I have explained to Cassandra that my goal is to give her the best chance at cure possible and that I understand that she has concerns about the toxicity of therapy. I have again tried to reassure her that while there are risks that chemotherapy carries, the serious risks are low. Certainly, risks such as hair loss are very high, but cardiac toxicity would be very low, I estimate at less than 1% for this therapy and given that we gave her a cardiac protectant and would for other doses too. I re-enforced that while I felt it was the right thing for her to receive treatment that I would not be making the decision to force her to undergo therapy. I reminded her that most patients in this situation are cured and that the risk of serious life threatening toxicity from the treatment was very low.

Michael S. Isakoff, MD

Revision History...

| Date/Time | User | Action |
|---|---|---|
| 12/16/2014 1132 | Michael S. Isakoff, MD | Addend |
| 12/15/2014 1846 | Nehal S. Parikh, MD | Sign |

View Details Report

Michael S. Isakoff, MD | Physician | Signed | Hematology/Oncology | *H&P* | Service date: 12/09/2014 1655

Connecticut Children's MEDICAL CENTER

**Cancer and Blood Disorders Services**
**Division of Hematology and Oncology**
*Connecticut Children's Specialty Group*

Patient Name: Cassandra L C
DOB: /1997
MRN: 0296846
Primary Care Provider: Hemant Panchal, MD

**Admission Note**

**Date**: 12/9/2014

**Chief Complaint**: Partially treated Hodgkin's lymphoma

**HPI**: 17 y/o female with Stage III Hodgkin's lymphoma, complex family dynamics delaying diagnosis and full staging work-up. After pathology showed HD, a treatable and curable malignancy for the majority of patients, mother and Cassandra have not been compliant with medical recommendations or treatment. After a second opinion at Baystate and numerous attempts to initiate a treatment plan, DCF involvement was required due to risks of disease progression and death. On November 17th, she started cycle 1 vincristine, etoposide, prednisone, doxorubicin (OEPA). Cassandra refused port placement, therefore she received vincristine via peripheral vein administration. Unfortunately, she had IV infiltration with the peripheral vesicant therapy and required 2 IV's to administer the day 1 chemotherapy, which was complicated by bruising at the site of those IV's but no sign of tissue damage. Due to concern for difficult IV access she was scheduled for port placement on 11/19, but disappeared, required a Silver Alert. Today, her case was brought to court and medical decision making rights were given to DCF and Cassandra was brought to clinic for admission for further care, including psychology/psychiatry evaluation and therapy with the potential for starting chemotherapy in the next 5-10 days. Cassandra reports that she is feeling fine. She notes that her neck adenopathy has been improving. She does not feel ill, though she has had some hair loss following chemotherapy on day 1 and 2. No N/V.

**ROS**: Review of Systems
Constitutional: Negative for fever, chills, diaphoresis, activity change, appetite change, fatigue and unexpected weight change.
**No night sweats or wt loss**
HENT: Negative for nosebleeds, congestion, sore throat, facial swelling, rhinorrhea, mouth sores, neck pain and neck stiffness.
Eyes: Negative for pain, itching and visual disturbance.
Respiratory: Negative for cough, chest tightness, shortness of breath and stridor.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for nausea, vomiting, abdominal pain, diarrhea and constipation.

Genitourinary: Negative for dysuria and frequency.
Musculoskeletal: Negative for back pain and arthralgias.
Skin: Negative for pallor and rash.
Neurological: Negative for dizziness, syncope, speech difficulty, weakness, light-headedness, numbness and headaches.
Hematological: Positive for adenopathy. Does not bruise/bleed easily.
Psychiatric/Behavioral: Positive for behavioral problems.

**Birth History**: No birth history on file.

**Past Medical History**:

**Past Medical History Pertinent Negatives**

| Diagnosis | Date Noted |
|---|---|
| • Prematurity, fetus 35-36 completed weeks of gestation | 9/12/14 |
| • Allergy, unspecified not elsewhere classified | 12/9/14 |
| • Immune myopathy | 12/9/14 |

**Past Medical History**

| Diagnosis | Date |
|---|---|
| • Lymphadenopathy<br>*Per CT scan-Extensive cervical, supraclavicular, mediastinal and retroperitoneal* | |
| • Other malignant neoplasm without specification of site | |

**Family History**: family history includes Anesthesia problems in her mother. There is no history of Bleeding disorder.

**Surgical History:**
No past surgical history pertinent negatives on file.

**Past Surgical History**

| Procedure | Date |
|---|---|
| • Lymph node biopsy | |

**Social History**:

**History**

Social History

| | |
|---|---|
| • Marital Status: | Single |
| Spouse Name: | N/A |
| Number of Children: | N/A |
| • Years of Education: | N/A |

Social History Main Topics

| | |
|---|---|
| • Smoking status: | Never Smoker |
| • Smokeless tobacco: | None |
| • Alcohol Use: | No |
| • Drug Use: | No |
| • Sexually Active: | None |

| Other Topics | Concern |
|---|---|
| • None | |

Social History Narrative
• None

**Medications:**

**Current Outpatient Prescriptions**

| Medication | Sig | Dispense | Refill |
|---|---|---|---|

| | |
|---|---|
| • acetaminophen (TYLENOL) 325 MG tablet | Take 650 mg by mouth every 4 (four) hours as needed |
| • multivitamin tablet | Take 1 tablet by mouth daily |

**Allergies**: Review of patient's allergies indicates no known allergies.

**Physical Exam**:
Blood pressure 133/69, pulse 98, temperature 37 °C (98.6 °F), temperature source Tympanic, resp. rate 17, height 163.6 cm (5' 4.41"), weight 84.5 kg (186 lb 4.6 oz), SpO2 100.00%.

Physical Exam
Constitutional: She appears well-developed. No distress.
HENT:
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.
Neck: Neck supple.
Cardiovascular: Normal rate and regular rhythm.
No murmur heard.
Pulmonary/Chest: No stridor. No respiratory distress. She has no wheezes.
Abdominal: Soft. She exhibits no mass. There is no tenderness.
Musculoskeletal: She exhibits no edema.
Lymphadenopathy:
She has cervical adenopathy.
Neurological: She is alert.
Skin: No rash noted.
Psychiatric: She has a normal mood and affect.

**Assessment and Plan by Problem:**
Cassandra is a 17 y.o. female being admitted for Coping style affecting medical condition

Patient Active Hospital Problem List:
Coping style affecting medical condition
Assessment: poor judgment with high risk behaviors in light of treatable malignancy
Plan: Consult Dr. Mangini - she is aware of patient
Behavioral health continuous obs.
Please clarify with Dr. Mangini tomorrow if Cassendra will require one-to-one continuous obs or general continuous obs

Hodgkin's lymphoma
Assessment: Advanced stage Hodgkin lymphoma partially treated with OEPA-COPDAC therapy. One of the goals of this therapy is to eliminate radiation if there is a complete metabolic response to initial treatment (following course 1 and 2). In this case Cassandra has received day 1 and 2 of therapy, including Dox and Vcr day 1, 2 doses of steroids, and 1 dose of etoposide. Today is day 23 of the chemotherapy course 1. The options at this point, include starting all of therapy over or continuing along treatment path skipping doses missed. In keeping with the goal of trying to eliminate radiation our plan will be to stay within the treatment plan of 2 cycles, each given over 28 days, and then evaluate PET response with a goal of eliminating radiation if there is a complete response. If we start over rather than skipping the missed doses, we would then treat outside of the guidelines, including extra chemo over a longer period of time and therefore we could not use PET response to determine use of radiation therapy. Thus, by starting over we would require radiation therapy.
Plan: Continue treatment plan, hopefully with agreement from Cassandra following further discussion and psychological help.

**Signed**: Kathleen M. O'Leary, APRN/Michael S. Isakoff, MD

I reviewed the notes above and I personally saw and evaluated the patient with Kathleen O'Leary. I agree with the assessment and plan.-Michael S. Isakoff, MD

Revision History...

| Date/Time | User | Action |
|---|---|---|
| 12/09/2014 2159 | Michael S. Isakoff, MD | Sign |
| 12/09/2014 1815 | Kathleen M. O'Leary, APRN | Sign |

View Details Report

SUPERIOR COURT - JUVENILE MATTERS
CHILD PROTECTION SESSION
MIDDLESEX JUDICIAL DISTRICT
AT MIDDLETOWN, CONNECTICUT

IN RE: CASSANDRA C.
NO: CP14-014681-A

NOVEMBER 12, 2014

BEFORE THE HONORABLE CARL E. TAYLOR, JUDGE

A P P E A R A N C E S :

Representing the Petitioner:

ATTORNEY ROSEMARIE WEBER
Assistant Attorney General

Representing the Respondent Mother:

ATTORNEY EDWARD JOY

Representing the Minor Child/Children:

ATTORNEY ANDREAS SPOERK

Guardian Ad Litem:

ATTORNEY JON DAVID ANTHONY REDUCHA

Also Present:

MARGARET NARDELLI, SOCIAL WORKER
KIMBERLY KANAITIS, NURSE
Department of Children and Families

Recorded By:
Danielle Lorenzen

Transcribed By:
Danielle Lorenzen
Court Recording Monitor
One Court Street
Middletown, Connecticut 06457

C A S S A N D R A C . ,

Having been duly sworn under oath by the Clerk, the witness testified as follows:

THE CLERK: Please be seated. Please state your name for the record.

THE WITNESS: Cassandra C., C-A-S-S-A-N-D-R-A (the witness spelled her last name.)

THE COURT: You may proceed.

DIRECT EXAMINATION BY ATTY. SPOERK:

Q Now, Cassandra, don't be bashful, speak up a little bit so we all can hear you, okay, because I don't think the mikes are on.

Now, Cassandra, how old are you?

A I'm 17.

Q Okay. And now, do you have a job?

A Yes, I do.

Q Okay. And have you worked in the past?

A Yes, I have. I've been working since I was 14.

Q Okay. And what have you done for your work experience?

A I've done paper routes, babysitting, and I currently work in retail at the Justice Store in the Enfield Mall.

Q Okay . And now, you've been doing a lot of work. Why do you need to work so much? What do you do with your money?

A I like to save it. I pay my own bills. I buy my own clothes. I pay for my phone. I like to have the ability to

A Partially. Like, I believe that if DCF didn't take me away, eventually I would have mentally accepted doing chemotherapy. And now that they've taken me and placed me somewhere where I do not like being and I'm uncomfortable - and I didn't know that I would be uncomfortable there. Originally I thought I would be comfortable there, but I'm not comfortable there. And I decided that I do want to do chemo, but I want to do it at home like I originally would have done.

Q Okay. So what's the big deal about you wanting to be home?

A Because home is home, that's where my cat is. It's like the smell in the morning when you wake up and the candles and my mom is there and it's just everything.

Q Okay.

A I really miss my home.

Q Okay.

A My mom is everything that I have. And you guys took me away from my mom, and she is the only person that I have.

Q Okay. Now, let me let you compose yourself a little bit.

(Brief pause in the proceedings.)

Q Now, one of the worries that we're all here - that we're worrying about is if we send you home, you're going to refuse the chemotherapy just to get home.

If for some reason it's decided that you should be allowed to go home and the appointment is next Monday, are

you going to go to that appointment?

A If you let me go home today, I would start chemo tomorrow.

Q Okay.

ATTY. SPOERK: I have no further questions, Your Honor.

THE COURT: All right. Mr. Joy.

CROSS-EXAMINATION BY ATTY. JOY:

Q Cassandra, as you know, I represent your mom.

It was mentioned that you home school?

A Yes.

Q And exactly how does that work?

A We buy textbooks that follow, like, the basic school curriculum. I study them. I highlight them. I read them. I take notes. I write everything down. My cousin is a school teacher. She has given me textbooks from an actual high school that are current, up to date textbooks that all the students are using.

Q How long have you been home schooled?

A I did my entire freshman year of high school. So sophomore, junior year I've been home schooled, and I would be a senior this year.

Q What was the reason for home school?

A There was a lot of problems at Windsor Locks High School. I originally wanted to do a twilight program, like an alternative education, and they decided not to let me do that because of my age. And there was just a lot of issues

with teachers, with everything, and I just wanted to be out. I wanted a different -

Q Have you been engaged in the home schooling since you were removed?

A Yeah.

ATTY. JOY: No further questions.

THE COURT: Thank you. You may proceed.

CROSS-EXAMINATION BY ATTY. WEBER:

Q Good afternoon, Cassandra. I know this is very difficult for you, so I really appreciate your honesty here today.

Cassandra, do you know you have cancer?

A Yes.

Q And do you know what kind of cancer it is?

A Yes.

Q And what is it?

A I know that I have Hodgkin's Lymphoma.

Q Okay. And do you know that you're going to die if you don't get treatment?

A Yes, I do.

Q And did you meet with Dr. Isakoff about that fact?

A Yes, I did.

Q And what did he explain to you?

A He explained to me, like, where the cancer is in my body. He explained what treatments he would use, and he explained the side effects of the treatments.

Q And did he tell you that you needed to have

chemotherapy?

A Yes.

Q And did you tell him you didn't want chemotherapy?

A Yes, I did.

Q And now, do you understand that the treatment is going to be very hard?

A Yes.

Q And that you may experience fevers?

A Yes.

Q And you may have to be hospitalized in between?

A Yes.

Q And despite that, you're willing to go no matter what to get treatment to cure your disease - to try to cure your disease?

A I don't want to be in the place or the situation I am to go through all that with you saying how hard it's going to be. I need to be home for that. I'm all ready in a situation that I don't want to be in. And to go through chemo, I don't want to add onto that. It's stressful, and it's hard. And I want to be home to go through that.

Q Do you want to live?

A Yes.

Q So will you go through chemotherapy?

A If I can go home.

Q And if you don't get to go home today?

A Then I'm not doing it.

ATTY. WEBER: No further questions, Your Honor.

required at the end of the year?

THE WITNESS: I -

THE COURT: Have they been filed?

THE WITNESS: I don't know anything about that.

THE COURT: Okay. And so your position is that if you don't get to go home, you don't want to do the chemo?

THE WITNESS: Yes.

THE COURT: So you'd rather die than - if you don't go home; is that about it?

THE WITNESS: I'm all ready in an uncomfortable situation and I know -

THE COURT: Just answer the question -

THE WITNESS: - that chemo -

THE COURT: - yes or no.

THE WITNESS: Yes, I would.

THE COURT: And have you given that some thought?

THE WITNESS: I have given it a lot of thought.

THE COURT: All right. Thank you very much.

Any questions based on my questions?

ATTY. SPOERK: No, Your Honor.

ATTY. JOY: No, Your Honor.

ATTY. WEBER: No, Your Honor.

THE COURT: All right. All right. You step down. Thank you.

You may call your next witness.

SUPERIOR COURT - JUVENILE MATTERS
CHILD PROTECTION SESSION
MIDDLESEX JUDICIAL DISTRICT
AT MIDDLETOWN, CONNECTICUT

IN RE: CASSANDRA C.
NO: CP14-014681-A

NOVEMBER 12, 2014

C E R T I F I C A T I O N

I hereby certify the foregoing pages are a true and correct transcription of the audio recording of the above-referenced case, heard in Superior Court, Judicial District of Middlesex, Middletown, Connecticut, before the Honorable Carl E. Taylor, Judge, on the 12th day of November, 2014.

Dated this 27th day of November, 2014 in Middletown, Connecticut.

Danielle Lorenzen
Court Recording Monitor

SUPERIOR COURT - JUVENILE MATTERS
CHILD PROTECTION SESSION
MIDDLESEX JUDICIAL DISTRICT
AT MIDDLETOWN, CONNECTICUT

IN RE: CASSANDRA C.
DOCKET NO. CP14-014681

DECEMBER 9, 2014

BEFORE THE HONORABLE BARBARA M. QUINN, JUDGE

A P P E A R A N C E S :

Representing the Petitioner:

ATTORNEY ROSEMARIE WEBER
ATTORNEY JOHN TUCKER
Assistant Attorney General

Representing the Respondent Mother:

ATTORNEY EDWARD JOY

Representing the Minor Child:

ATTORNEY ANDREAS SPOERK

Guardian Ad Litem for Minor Child:

ATTORNEY JON REDUCHA

Also Present:

MARGARET NARDELLI
MAUREEN DUGGAN
MARIO PERLECHE
Department of Children and Families

Recorded and Transcribed By:

Pamela Gendreau
Court Recording Monitor
One Court Street
Middletown, CT 06457

M I C H A E L  I S A K O F F,

Having been first duly sworn by the clerk, was examined and testified as follows:

THE CLERK: Please state your name, spell your name, and state your business address, please.

THE WITNESS: Michael Isakoff. You said spell my name? M-I-C-H-A-E-L-I-S-A-K-O-F-F. Connecticut Children's Medical Center. It's 282 Washington Street, Hartford, Connecticut, 06106. Thanks.

ATTY. WEBER: Thank you, Your Honor.

DIRECT EXAMINATION BY ATTY. WEBER:

Q You've just indicated where you work, CCMC, and you previously testified in this matter; is that correct, Dr. Isakoff?

A That's correct.

Q Okay. And I recall that you hold several positions at CCMC. Can you please describe for the Court, so she has some familiarity with your work, the positions that you hold and your duties and responsibilities in those positions?

A Yes. So I am the medical director for the Division of Hematology and Oncology at Connecticut Children's Medical Center. In that role, I primarily focus on the clinical operations and management of patients. I also am the clinical director of the -- or the medical director for the Clinical Trials Unit for the whole hospital, where I help guide clinical trials throughout the hospital.

And I'm the principle investigator for the Children's

Oncology Group, which is our national consortium for research in childhood cancer. I am on the National Bone Tumor Committee for the Children's Oncology Group and sit on the Protocol Development Committee for a phase one clinical trial small consortium called the Sunshine Project that involves thirteen hospitals around the country for early novel therapeutic clinical trials.

Q And approximately how many patient visits do you have in a year, if you could estimate?

A So last year, in the last fiscal year, our -- we had 8,900 visits to our clinic.

Q Now when you were last in court, the Judge also found you to be an expert in the area of pediatric hematology and oncology; do you recall that?

A Yes.

Q Okay. And when you were last in court, we asked you a lot of questions about Hodgkin's lymphoma and Cassandra's treatment. And without going into the detail that you went into in our last court appearance, I'd like you to summarize for the Court Cassandra's diagnosis, staging, and her prognosis.

A Sure. Cassandra was diagnosed with classical Hodgkin's lymphoma with the nodular sclerosing subtype, which is the most common type that we typically see. She was staged with CAT scan and PET scans to both look at size of any lymph nodes or masses and the activity of those masses with the PET scan.

She was determined, based on those imaging studies, to have stage three disease. We could not determine stage four disease without doing a bone marrow evaluation. We had a question of two small nodules in the lung that could represent inflammation and so we could not definitively say that that was disease with those scans.

And so we proceeded with a diagnosis of stage three Hodgkin's lymphoma, understanding that we could -- that there could be bone marrow disease that we don't know about.

From a prognostic standpoint, I had noted that I felt comfortable not knowing about the bone marrow result because the difference between stage three and stage four is not very much. So that it wouldn't change therapy and it would have minimal impact on prognosis. I felt that in general, advanced stage, which is stage three Hodgkin's we refer to as advanced stage, we do consider to be a curable disease.

The therapy that I recommended is reported to have outcomes in the clinical trial, that it was used to establish its efficacy and as a standard of care option, had an eighty five percent, five year disease free survival. That indicates survival without any sign of recurrence of disease. So we talked about that last time.

The therapy that we design is based on this protocol which may be attempt at maintaining a high curability while decreasing some of the toxicity that can be associated with chemotherapy. Some of the greatest risks that we worry about are risks to the lung in terms of lung function and

also long term fertility risks. And this particular regimen takes into consideration both of those issues.

There are still a number of toxicities with chemotherapy that we reviewed and in the consent document that I had put together, went through the likely, less likely, and rare but serious side effects for the group of drugs that we do use.

The other aspect of therapy that I feel is critical for young people, especially young girls, is the attempt to avoid radiation therapy which historically has been part of standard of care. But over time, there's been more push to avoid radiation by assessing the degree of response after a certain number of courses of therapy.

So in the protocol that I recommended, we give two courses that each last a month and then we re-assess with a PET scan to look at the metabolic activity. And if there's a complete metabolic response such that there does not appear to be PET activity, then we can eliminate radiation therapy from the treatment. If there is less than a complete response, then we cannot eliminate radiation.

The goal is at least, you know, for, you know, forty to sixty percent of patients will be able to avoid radiation in that case. And so we like to avoid that because there's a secondary risk of cancer, including breast cancer, and that risk is concerning enough that any attempt to eliminate radiation, in my opinion, is a good attempt.

Q So, Doctor, when you -- the course of treatment that

you recommended, if you could describe for the Court how that looked on a day to day basis?

A So the treatment, initially the first two courses involve four different drugs. They're -- some of them are -- or one of them is given orally and that's given for fifteen days in a row. That's a steroid that's given for fifteen days.

On day one, two chemotherapy agents are given on the same day and then day two through six, there's a -- the fourth drug is given daily for those days.

And then in between, after that six day period -- which is typically done as an outpatient. Although there are some patients that have significant nausea and need to be admitted for the therapy, but we try as much as possible to do it as an outpatient.

Typically once that sixth day is done, if patients are doing well, then we follow their blood counts twice weekly. And then on day fifteen, there's more chemotherapy given and, as I said, during those first fifteen days, there's oral chemotherapy for all fifteen. Back in clinic on day fifteen for more chemotherapy and then following blood counts over the next two weeks and then you do the same thing over again.

After the assessment of response, we switch to a four drug regimen that is given over the course of -- monthly courses that are given for four courses. So that the total treatment, if there's no delays and everything is going

well, is a total of four -- of six months total.

Q So, Doctor, now when we -- when you were last in court, following that, did Cassandra engage in treatment?

A She did. She came in on day one of therapy. She got her IV and we gave her the day one treatment. The day one treatment was a little bit complicated because the nurses attempted to do it in a peripheral IV, which for some patients is perfectly fine. And Cassandra, you know, expressed her wish not to have a port-a-cath and we had discussed previously on a few different occasions that we could attempt to do that and in some patients, that's successful.

But in her case, the issue is -- I should say that when you infuse the chemotherapy, if it leaks out of the vein or the vessel is not -- does not have an IV that's staying well, then you get leakage and the leakage can cause damage to the subcutaneous tissue and the muscles underneath and it's what we call a vesicant and so two of the drugs on day one are vesicants.

The nurses who have, you know, are specially -- have to be specially certified to be able to do vesicant therapy and so there's only a few nurses in our clinic that have that higher level of certification and so they did it. And, you know, in my opinion, they're the best nurses that I've seen put in an IV. So I trust their ability to do it on almost anybody.

But Cassandra does has what I would call fragile

veins and they're not big bulging veins. So we knew that there'd be some risk and they did have infiltration during the first infusion and she had bruising around there. So they immediately stopped, switched to another vein, and they did complete the infusion. And then they were able to give the other chemotherapy that's not a vesicant.

Q So, Doctor, if I could stop you there? Just to back up, when you were here last, we did talk about the method by which the chemotherapy would be administered, whether it would be through a port-a-cath or through her veins. And did you have a discussion with Cassandra on what she preferred?

A Yes.

Q And what was that?

A Through her vein.

Q And did you describe to her what the possible complications might be?

A Yes.

Q Okay. And based on that discussion, what was your understanding -- or withdrawn.

What was -- how were you going to proceed with administering the chemotherapy if it failed by vein?

A So based on our conversation, my understanding was that if we could not do it by vein, that she would agree to a port-a-cath.

Q Okay. And so you understood that she agreed to a port-a-cath if it didn't work?

A If it didn't work, that she would agree to a port-a-cath.

Q Okay. And you indicated that she started day one of treatment and that -- did that go without incident?

A No incident at all.

Q Okay. And did you meet with her on that day?

A Yes.

Q And when was the next day that she returned for treatment?

A The next day, she returned for day two. On that day, it doesn't involve vesicant therapy. So the nurses were able to place the IV in a different vein and gave her that day's treatment without any incident.

I did go in to talk to her about -- well, I went in to, I'm sorry, to look at her arms to make sure she wasn't having any signs of destruction of tissue essentially and she only had a small amount of bruising. I felt comfortable that the bruising may have been the vein breaking, but that it didn't -- I didn't see any appearance that was concerning for subcutaneous damage.

But after looking at it and seeing the bruising and knowing what happened the prior day, we discussed at that point that she would need to have a port-a-cath placed.

Q And what was Cassandra's response?

A I mean initially she responded to me as I knew you were going to say that. She indicated that one of the nurses prior to my coming in had looked at her veins and had

talked to her about that. So she did not seem surprised by it. And with me, she did not disagree with it.

Q Now who was present at that meeting?

A Workers from DCF, Cassandra, and a nurse, and our nurse practitioner.

Q Okay. Was her mother present that day?

A No.

Q Okay. And did you have a discussion with Cassandra's mother regarding insertion of a port-a-cath?

A Prior to that, I did. On that day, I did not. One of our nurses called her mom. Her mom had called into clinic and asked to speak to me and I was still seeing patients. And so the nurse spoke to her for about thirty minutes and when I saw her later, she said that I didn't -- that her questions were answered and mom said that I didn't need to call her.

Q Okay. And based on that, what was the plan going to be from day two on?

A So we -- I then called the surgeon to see if we could get her put on the schedule for a port-a-cath as soon as possible. I figured once it was in, you know, will make her life easier in terms of accessing her. So if we were going to do it, we might as well do it as quickly as possible. So the surgeon was being as flexible as possible and they were able to put it on for the next morning. So that he could put it in, leave her accessed, and then just come right up to clinic so that she can just get her treatment that day

with the port access. So that was supposed to happen at 7 in the morning the following day.

Q And did that happen at 7 in the morning the following day?

A No.

Q And to your knowledge, why didn't that happen?

A Cassandra was missing at that point.

Q Okay. What was your understanding of Cassandra's status?

A Of her -- I just knew that she was missing and nobody could find her at that point.

Q Okay. And do you know how long she was missing for approximately?

A I think like the next five or six, seven days, somewhere in that range. I don't know the exact number.

Q And during that period of time, was Cassandra supposed to be undergoing chemotherapy treatment with you?

A Yes.

Q Okay. So it's safe to assume that she didn't come in to seek that treatment?

A No. She did not get day three through six of the chemotherapy and did not take -- as far as I understood, was not taking the oral steroids at home either.

Q And is Cassandra currently in treatment?

A No.

Q So since day two, Cassandra has not been in treatment, to your knowledge, for her Hodgkin's lymphoma?

A No.
Q Now can you tell us what the impact or the consequences are of Cassandra's missed treatment?
A So partial treatment can lead to resistance to chemotherapy which can make treatment more difficult once or if she does receive treatment which can decrease her curability.
Q Now were there -- could there be other complications that arise as a result of her missed treatment?
A I mean if she doesn't get any treatment after that partial treatment, then her disease will grow and, you know, will be -- at some point will lead to her dying.
Q So to put it plainly, Doctor, without treatment, without further treatment, what is Cassandra's prognosis?
A So without further treatment, her prognosis is certain death.
Q Now at some point, she did re-appear; is that correct?
A That's correct.
Q And did you meet with her after she re-appeared?
A She came back into clinic on the following Monday that she -- after she re-appeared, I believe the weekend -- during the weekend.
Q Okay. And did you meet with her?
A Yes.
Q Can you tell us about that discussion with her?
A So we talked about how she was feeling, which she

told me that she was feeling fine at that point. She didn't feel nauseated. She didn't feel sick, she reported, in any way.

I talked to her about whether she was willing to do therapy or not and she indicated that she was not. I talked to her about the issues that we just reviewed; that if without treatment, that she would die of disease. And she acknowledged that she heard me saying that. She did not acknowledge that she necessarily agreed with me, but she didn't say anything to disagree.

We -- I reflected to her my concern that her decision making seems to be quite poor and that I couldn't understand why she would not be continuing therapy after all of the things that we've talked about. She indicated to me and specifically told me that she only agreed to do the therapy so that she would get back in mom's home and told me that she would not -- she knew that she wasn't going to continue the therapy once she started.

To that, I told her that that decision was really a bad one in my opinion because it puts her in the position of getting partially treated, which then when she -- if she decides later to get treated, could lead to her getting treated in a situation of resistant disease. And that if she really felt that way, I felt that she should have disagreed with the court order then and not put herself in a position where she could be affecting her own prognosis.

Q So to be clear, Doctor, she told you that she only

agreed to the chemotherapy in order to get back into the home?

A That's correct.

Q Okay. But that when she said that, it was never her intention to follow through?

A That's correct. That's what she said.

Q And now her decision making, you discussed that. Is Cassandra -- she's seventeen years old, correct? In your opinion, is she competent to make a decision such as that?

A Based on the conversations that I've had with her, I have felt that she's not competent. She did ask me specifically, you know, if I was eighteen, I wouldn't have this going on. And I acknowledged that if she was eighteen, there might be a different scenario going on. But I also told her that, in my opinion, if she was eighteen and making the decision not to get treated for a curable cancer, that that to me would put into question her competency even as a legal adult.

Q And when you met with her, did you also speak with her mother at any time

A Not during that -- at that time, her mom was not present.

Q Okay. Have you had any subsequent conversations with her mother since her re-appearance?

A No.

Q So to your knowledge, is mother making any informed decisions with regard to Cassandra's treatment?

A I mean I'm not aware of her making any informed decisions at this point.

Q Doctor, what would your recommendation be in terms of who should be making decisions for Cassandra?

A Well, I mean I think based on what I've seen and what we've been through, I think that -- I mean it's hard to say for me, you know. I kind of feel like I should make decisions for her, but --

Q Fair enough. Let me ask another question. Do you think that Cassandra's competent to make decisions regarding her medical care?

A I don't.

Q And how about her mother?

A I mean based on our conversations previously, I've -- I mean the short answer is I don't. I don't know if you need me to expand on that, but --

Q Well, if you can explain the basis for your opinion?

A Yeah. I mean I think that when presented with the facts of a cancer diagnosis -- although I feel for any parent who has to watch their child going through therapy, where I sort of lose the ability to understand competency or to think that someone's not competent to make the decision is being presented with the facts of a cancer diagnosis that is curable in the majority of cases and then not forcing your child to get that therapy. And making statements that you, you know, that you don't, you know, want her to get that therapy.

You know, mom early on had commented in our first meeting that she didn't, you know, that she wasn't going to let her get any poisons in her body and I validated for her that there is some basis to think that these are poisons. But these poisons are what can cure her and we had that conversation.

So I mean I can feel for her on -- for the majority of her concerns of not wanting chemotherapy, but I don't -- but the part that gets every other parent over that is the concern that nobody wants their child to have cancer. So you might not want them to have therapy, but there's a disconnect between not wanting therapy and the fact that she has cancer.

And so a part of me has felt that mom either is not competent or doesn't believe the diagnosis, but the fact that she still doesn't -- if it's true that she doesn't believe the diagnosis, then there's a disconnect there too because we've had a second opinion in -- at Baystate that's confirmed the diagnosis. I have no question about the diagnosis. I even sent a pathology to Boston Children's Hospital so that they could look at it at Boston Children's and Dana-Farber and they agreed with the diagnosis.

I, you know, I can't make a connection there that seems rational to me of how any parent would not force their child and convince them that despite the chemotherapy being scary and potentially horrible, that that is what you need to do to have a chance at surviving.

Q So let me ask you this, Doctor, as a scenario. If the Court were to order that DCF make the medical decisions on Cassandra's behalf and DCF wanted to follow your recommendations for treatment, what would you and CCMC do to help DCF facilitate that treatment?

A So I mean the first thing is I think we would need to hospitalize Cassandra so that we can get her evaluations by our psychology and psychiatric teams to assess all of the reasons why she feels the way she does. I think that we would need to meet with her regularly and discuss, you know, her concerns and how she feels. And we would be -- as a hospital, you know, we would be willing to then treat her as an inpatient and make sure she got all of her therapy.

One of my concerns just given that she started therapy and then disappeared would be that it would only confound the problem if -- in terms of the risk of resistance and putting her at greater risk if she did that again. And so I feel that although it could mean a very long hospitalization, that that seems to be what's in her best interest.

Q And that is something that you and the hospital would support?

A Yes.

ATTY. WEBER: If I could just have a moment, Your Honor? Thank you, Your Honor. I have no further questions.

THE COURT: Thank you. I don't know in what

A Right.
Q Were you aware that Cassandra's having a psychiatric evaluation Thursday?
A No.
Q Okay. Now if it was up to you, as you said, you'd put her inpatient in the hospital, correct?
A That's correct.
Q Now you said that maybe her mother or another therapist should try to convince her to get treatment?
A I'm not sure that's exactly what I said. I said that they should work with her to understand exactly what the issues are to resolve what her concerns are about getting treatment.
Q Okay.
A I think that's more in line with what I said.
Q So someone would -- you want to have understanding of why she doesn't want treatment?
A And an understanding of the disconnect between the issues that I spoke of before that also relate to the lack of competency that I see.
Q The issues meaning the medical --
A Meaning that she specifically decided to get treatment and chemotherapy knowing that she was going to stop it as soon as she got home. That that to me is -- that, in itself, raises competency questions.
Q Okay. Now --
A Because she specifically said that she doesn't want

these toxic poisons. She doesn't want to be exposed to the chemotherapy, but yet she was willing to get that therapy just to get home but not to cure her cancer. That disconnect is what raises her competency. You know, I've never been asked a question about competency before, but I certainly can think about whether I think a patient is competency in the hundreds of patients that I encounter over the years.

Q So you have a hard time grasping that my client wanted to get home and she was willing to do chemotherapy to get home knowing the risks --

A Knowing how she felt about chemotherapy, it is very hard for me to understand how someone would expose themselves to that therapy for that reason and also know at the same time they actually do have cancer.

Q Now --

A Yeah.

Q -- if my client was inpatient and you recommended the port-a-cath for the other chemotherapy treatments and even though my client would be saying no, she doesn't want them, you're going to force my client to do them?

A So I mean that's a complicated question and I would say that I personally am not going to hold her down to give her chemo. But the medical decision maker that I will for a second call the parent, they -- parents force their kids to get chemotherapy all the time. So if in this case her parent ends up being the state and they say she's getting

away.

The issue is that she is refusing treatment and if the Court orders treatment, we might be forcing her to react the way she did earlier in this case where she took off and ran away. If that's the case, then we have a sick child in an unsafe environment and there's no way to monitor her.

I believe the way the Court should handle it is the Court should order a mental health evaluation and require counseling regarding the treatment in order to assist Cassandra in re-evaluating her position on the treatment. And I believe that she needs to be on board with the treatment and that would be what's in her best interest.

And we need to be able to get her to that position, that she's on board and says, yes, this is -- I understand, this is what I want because, ultimately, treatment is in her best interest. The issue is how do we get to that position of treatment without losing her to running away again.

THE COURT: Thank you.

ATTY. REDUCHA: That's all I have. Thank you.

THE COURT: All right. As I understand Judge Taylor's orders and I'm sorry he's not here to hear the conclusion of this, he had already vested custody and care and control of Cassandra with the Department.

Having reviewed and listened to the testimony today and the testimony in transcript from the previous hearings, the Court does find that, unfortunately, you, Cassandra, have advanced high risk Hodgkin's lymphoma, which requires therapy for you to continue to be able to live. That part is clear.

I think it is very clear that your mother does not believe and distrusts this diagnosis despite three separate opinions and confirmations of the diagnosis and I think that she doesn't, at heart, believe that you need this treatment.

And I'm sorry, ma'am, but I don't find your testimony credible. I think you have done a lot to undermine what would be in your best interest and to encourage her because she is in your care and custody. You home school her. She does not have a great deal of outside contact with peers and other people in the community.

And so that is a problem in your family and I know you believe you're doing the right thing, but you have very highly trained physicians who've told you what the facts are and I don't think you believe them.

I do find that there have been considerable delays in follow up with appropriate treatment between the time of the initial diagnosis and the

time of the OTC hearing.

And at that OTC hearing, each of you, you and your mother, Cassandra, were given the opportunity and the Court believed you to do what you had asked of the Court and that is that you could be home and you could do the treatment.

Courts do not take kindly to being hoodwinked and to know that in your heart of hearts you have some other idea in mind.

Now your care and custody has already been vested in the Department of Children and Families and does not remain with your mother. That's a decision that was already made. So now it comes down to what happens next.

We heard the doctor talk about what he would propose and how we would work with you. We heard the Department say that they would come back to court from time to time to check in about your status and what was going to happen.

And we now have heard the Department talk about a no runaway order and I don't know if there's been an opportunity for you to talk with her about what that means and whether you'd like that opportunity on behalf of your client, if she violates a do not runaway order. Is she aware of what that means?

ATTY. SPOERK: I'll speak to my client, Your Honor.

THE COURT: Do you want to do that now?

ATTY. SPOERK: If you could give us some time outside, Your Honor?

THE COURT: Thank you. We'll stand in recess for approximately five minutes.

(Whereupon, the Court stood in a brief recess).

THE COURT: Good afternoon. All right. I think we're ready to continue.

So the Court will issue an order that you remain in DCF custody and care and that you not remain in the home with your mother.

The Court will order the Department to be entitled to make the appropriate medical treatment about which we heard testimony here today.

The Court will set down this matter for a period of two weeks for an in court review.

And the Court will also order that you not run away from your placement.

Are there any questions about the Court's order?

ATTY. SPOERK: Your Honor, I'd ask if she's not going to be placed in the home, that DCF provide transportation to her employment? Because the last placement, she had difficulty. DCF relied on the foster placement to provide transportation. She couldn't get to work, Your Honor.

THE COURT: Well, if DCF provides the care that's just been testified to, I don't suspect she

will be working but that'll be up to what the Department decides to do. But yes, if she is able to work, then DCF should provide for the transportation.

ATTY. SPOERK: Thank you, Your Honor.

ATTY. WEBER: Your Honor, if I could just ask for a clarification just so my notes reflect? Is it implicit in your order that DCF make the appropriate medical decisions, that the determination to go inpatient would also be one of those decisions?

THE COURT: That would be one of those decisions. Yes. Once you are -- have the care and custody, including the medical care of the child, that is where we are.

ATTY. WEBER: Okay. Thank you, Your Honor.

THE COURT: All right. Thank you very much for your presentation of this matter. We'll stand adjourned.

(Whereupon, the proceedings were concluded).

SUPERIOR COURT - JUVENILE MATTERS
CHILD PROTECTION SESSION
MIDDLESEX JUDICIAL DISTRICT
AT MIDDLETOWN, CONNECTICUT

IN RE: CASSANDRA C.
DOCKET NO. CP14-014681

DECEMBER 9, 2014

# C E R T I F I C A T I O N

I hereby certify the foregoing pages are a true and correct transcription of the audio recording of the above-referenced case, heard in Superior Court, Judicial District of Middlesex, Middletown, Connecticut, before the Honorable Barbara M. Quinn, Judge, on the 9th day of December, 2014.

Dated this 16th day of December, 2014 in Middletown, Connecticut.

Pamela Gendreau
Court Recording Monitor