2016 IL App (1st) 152229-U

THIRD DIVISION
March 9, 2016

No. 1-15-2229



IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

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| *In re* M.M., | ) | |
| | ) | Appeal from the |
| Minor-Respondent-Appellee | ) | Circuit Court of |
| | ) | Cook County, Illinois, |
| (People of the State of Illinois, | ) | Child Protection Division. |
| | ) | |
| Petitioner-Appellee, | ) | No. 13 JA 01132 |
| v. | ) | |
| | ) | Honorable |
| L.T., | ) | Maxwell J. Griffin, Jr., |
| | ) | Judge Presiding. |
| Guardian-Respondent-Appellant). | ) | |

PRESIDING JUSTICE MASON delivered the judgment of the court.
Justices Fitzgerald Smith and Pucinski concurred in the judgment.

**ORDER**

¶ 1 *Held*: Legal guardian appealed trial court's finding that 17-month-old child was neglected and abused. Although child was medically complex and his underlying medical issues were outside the guardian's control, evidence showed that she exacerbated his condition by disregarding his specific dietary needs, failing to bring him to clinic appointments, and delaying bringing him to the hospital in the face of his worsening condition. Additionally, expert medical testimony showed that bruises on the child's face were non-accidentally inflicted.

¶ 2 The State filed a petition for wardship over 17-month-old M.M., who was under the legal guardianship of his maternal grandmother, L.T. M.M. is a special needs child: he was born with necrotic intestines that had to be removed, leaving him with short bowel syndrome, a condition that occurs when the intestines are too short to absorb sufficient nutrients from food. On October 24, 2013, when he was 15 months old, he was hospitalized due to significant weight loss and bruises that were observed on his face. In its petition for wardship, the State alleged that M.M.'s weight loss was due to neglect; more specifically, it alleged that L.T. delayed seeking medical care for M.M., and he would be at risk of harm if left in her care. The State also alleged that M.M. had been abused, since L.T. did not have an adequate explanation for M.M.'s bruises.

¶ 3 Following several days of hearings, the trial court found that M.M. had been both neglected and abused, though it did not specify who perpetrated the abuse. M.M. was made a ward of the court and returned to L.T. under an order of protective supervision. L.T. appeals, arguing that the State failed to adequately prove neglect and abuse. She asserts that M.M.'s hospitalization was necessitated by his underlying medical problems, not by any lack of care on her part, and the record shows that she did everything medically necessary to care for M.M. We find that the trial court's ruling was supported by competent testimony and not against the manifest weight of the evidence, and we affirm.

¶ 4 BACKGROUND

¶ 5 M.M. was born on July 5, 2012, to Tabitha M. and Danny C. He was born at 32 weeks, weighed 3.5 pounds, and had PCP and marijuana in his system. He was born with a condition called gastroschisis, meaning that his abdominal wall did not close in utero and his intestines were exposed. Additionally, his intestines were twisted, and a large portion of the tissue was

dead because it had not received an adequate supply of blood. Shortly after his birth, M.M. underwent surgery to remove the necrotic tissue.

¶ 6 M.M.'s doctor at Mt. Sinai Hospital opined that M.M.'s conditions were likely nontreatable and fatal. Tabitha and her mother, L.T., sought a second opinion at Lurie Children's Hospital. Around a week after his birth, M.M. was transferred to Lurie, where he underwent additional surgeries to address his bowel issues. Because of his short bowel syndrome, he received supplemental nutrition from a gastrostomy feeding tube (G-tube) inserted into his stomach, as well as intravenous feeding administered through a total parenteral nutrition (TPN) line.

¶ 7 L.T. started the process of becoming M.M.'s legal guardian in November 2012 and was officially designated as guardian on February 13, 2013. M.M. remained in the hospital until March 18, when he was discharged to L.T.'s care. He was rehospitalized from July 25 to August 14 because of abnormal lab results. During this hospital stay, Lurie staff removed his TPN line in hopes that he could sustain himself without intravenous feeding. On October 25, M.M. was admitted to Lurie again because of weight loss and bruises on his cheeks and under his right eye. He was diagnosed with failure to thrive, both organic and non-organic. (Failure to thrive is a medical term indicating insufficient weight gain. It is organic when caused by a child's medical condition and non-organic when caused by the caregiver's actions.)

¶ 8 The Department of Children and Family Services (DCFS) took protective custody of M.M. on December 5, 2013. The next day, the State filed a petition seeking wardship over M.M. The State alleged that L.T. delayed seeking medical care for M.M., in spite of his special medical needs, and she could not adequately explain the bruises on his face. Based upon these facts, the

State contended that M.M. was both neglected and abused (see 705 ILCS 405 2-3(1), (2)(ii) (West 2012)).

¶ 9 At the adjudication hearing, the State called the following witnesses: Dr. Valeria Cohran, M.M.'s primary care physician at Lurie; Dr. Norell Rosado, a physician specializing in child abuse pediatrics at Lurie; and Shawn Tierney and Maxine Doss, nurses who provided in-home nursing services for M.M. at L.T.'s home. L.T. testified on her own behalf and also called Barbara Dailey, another of M.M.'s in-home nurses.

¶ 10 Dr. Cohran's Testimony

¶ 11 Dr. Cohran is a pediatric gastroenterologist at Lurie, specializing in patients with intestinal failure and short bowel syndrome. She was M.M.'s primary care physician and had cared for him since shortly after his birth in 2012.

¶ 12 M.M. was discharged to L.T.'s care on March 18, 2013, when he was eight months old. Prior to M.M.'s discharge, Lurie required L.T. to participate in a 24-hour training program at the hospital where she performed all of M.M.'s care under observation. After M.M.'s discharge, Dr. Cohran and the gastroenterology team continued to monitor his progress through reports from in-home nurses and from L.T. L.T. was the main person that Dr. Cohran relied on; as M.M.'s primary caregiver, her responsibilities included monitoring his TPN line, bringing him to clinic appointments, measuring his nutrition intake and stool output, getting his laboratory results, and notifying the hospital if any concerns arose regarding his condition. Close monitoring of M.M.'s condition was crucial because any deviation from the norm could quickly develop into a life-threatening situation.

¶ 13 Regarding M.M.'s dietary needs and restrictions, Dr. Cohran stated that children with short bowel syndrome cannot absorb nutrients properly and require a "broken-down formula"

that is easier to digest. The formula's ingredients are determined by the child's doctor, but the caregiver is responsible for mixing the formula and providing it to the child. It is important for the caregiver to maintain close contact with the doctor's office so that the doctor can adjust the formula or feeding schedule as needed. Because of this, L.T. was told to report to the clinic every two weeks.

¶ 14 At the time M.M. was discharged from the hospital, he was receiving the majority of his calories through his TPN line, and he was also receiving nutrition through the G-tube. He was only receiving "[v]ery minimal" calories by mouth. Dr. Cohran explained that children with short bowel syndrome are unable to absorb most foods that a healthy child would typically eat. Eating such foods can lead to diarrhea, severe diaper rash, dehydration, and weight loss. For this reason, Dr. Cohran instructed L.T. not to give M.M. high-sugar foods such as juice.

¶ 15 M.M. was readmitted to Lurie on July 25, 2013. He was admitted because of abnormal lab results and because Dr. Cohran's team had been unable to reach L.T. for approximately two weeks prior to his admission. L.T. failed to report to the clinic as scheduled, and her voice mail was full, so Dr. Cohran could not leave messages for her. Dr. Cohran said that this was a "huge problem" because she was unable to properly prescribe M.M.'s TPN formula without knowing how he was progressing. It turned out that L.T. had placed M.M. in a children's nursing facility called Almost Home For Kids without notifying Dr. Cohran's team. Dr. Cohran's team only found out about this placement when they were called by a representative from Almost Home, who informed them that he was going to run out of formula for M.M.

¶ 16 During M.M.'s hospital stay, near the end of July, Dr. Cohran's team removed his TPN line. Dr. Cohran explained that maintaining the TPN line was a health risk because it went into a major blood vessel in his chest and could potentially break or become infected. Thus, it would

be better if he could sustain himself without it. After the TPN line was removed, while he was still in the hospital, M.M. continued to gain weight and his lab data was normal.

¶ 17 On August 8, 2013, before discharging M.M. to L.T.'s care, Dr. Cohran's team signed a medical agreement with L.T. Such agreements are rare – Dr. Cohran had not put one in place since 2006 or 2007 – but she felt it was necessary in M.M.'s case because she was concerned about L.T.'s lack of contact. In the agreement, L.T. promised to bring M.M. to clinic appointments every two weeks and call in his weight on a weekly basis. She also agreed to avoid feeding M.M. high-sugar foods and milk products. Dr. Cohran said that this was a concern because L.T. was still "persistently" giving juice to M.M. despite Lurie staff telling her on multiple occasions that he should not be drinking juice.

¶ 18 M.M. was once again discharged to L.T.'s care on August 14, 2013. She brought M.M. to clinic appointments on August 28 and on September 23. At the September 23 visit, M.M. was doing "very well"; he was gaining over an ounce of weight a day and was experiencing no problems with his TPN removal. But over the next month, L.T. did not bring M.M. to clinic visits, did not call to report his weight (in violation of the medical agreement), and did not call to report any issues with his care.

¶ 19 On October 24, one of M.M.'s home-care nurses called Dr. Cohran, stating that M.M. had lost significant weight and appeared to have bruising on his face. L.T. also called and reported that M.M.'s weight was significantly down. She said that M.M. had been experiencing vomiting and diarrhea for the past two weeks.

¶ 20 Early on the morning of October 25, L.T. brought M.M. back to Lurie. When Dr. Rosado saw M.M., he looked thin, withdrawn, and unhappy, and he had bruises on his face. He appeared

to be very frightened of strangers, behavior which he had not previously displayed. He weighed 15.5 pounds, which was a one- or two-pound loss since his last clinic visit on September 23.

¶ 21 Dr. Cohran diagnosed M.M. with failure to thrive, both organic and non-organic. She stated that removal of M.M.'s TPN line was not the sole cause of his failure to thrive. M.M.'s underlying short bowel syndrome was a contributing cause, but his problems were exacerbated by L.T.'s failure to maintain contact with hospital staff as described in the medical agreement. In particular, L.T. failed to notify hospital staff that M.M. was experiencing vomiting and diarrhea for the two-week period prior to his admission, which delayed his treatment and caused him to lose additional weight. Dr. Cohran opined that L.T.'s lack of contact with hospital staff during that time period constituted medical neglect.

¶ 22 When M.M. was admitted to the hospital, he was placed on the same feeding regimen that he was supposed to have received under L.T.'s care, but he did not gain weight and was having significant diarrhea, so his TPN line was re-inserted. He was still receiving TPN feedings as of the date of Dr. Cohran's testimony (May 2014), though she said that she hoped to stop such feedings within the next year.

¶ 23 Regarding the allegations that M.M. had been abused, Dr. Cohran stated that abuse was not her area of expertise. On cross-examination, she stated that short bowel syndrome, in and of itself, does not cause individuals to be more susceptible to bruising. But one complication from short bowel syndrome is that the body is unable to absorb important vitamins and minerals, which can potentially cause patients to bruise more easily.

¶ 24 Dr. Rosado's Testimony

¶ 25 Dr. Rosado is an attending physician at Lurie in the division of child abuse pediatrics. He is board-certified in pediatrics and child abuse pediatrics and was admitted as an expert witness

on both subjects. On October 25, 2013, the Lurie Child Protection Services team asked Dr. Rosado to consult on M.M.'s case because M.M. had bruises on his face and the hospital staff was concerned that they could have been non-accidentally inflicted.

¶ 26 M.M. had three bruises on his face: one on the side of his right eye, one on his right cheek, and one on his left cheek. There were no other bruises on his body. Photographs of M.M.'s bruised face taken on October 24 were admitted into evidence. The bruises were all in different planes, meaning that "some of them were on the front of the body, some of them were on the side and on the other side, which means three different places of impact at some point." Based on the location of the bruises, Dr. Rosado was concerned that they were non-accidental. He explained that a typical 15-month-old child will reflexively protect his face if he falls or is going to hit something. Thus, most accidental bruises are on shins, knees, arms, or elbows, but not the face. Facial bruises are particularly concerning in non-ambulatory children, such as M.M., who was able to stand but not yet able to walk independently.

¶ 27 Dr. Rosado did not speak directly to L.T. about the cause of the bruises, but he talked with emergency room physicians, the gastroenterology team at Lurie, a social worker at Lurie, and representatives from DCFS. Based on these conversations, he said that L.T. had "no true explanation" for the cause of the bruises. In most interviews, L.T. was "not sure" where the bruises came from. In one interview, she said they might have occurred when M.M. was playing or sleeping with a toy. Dr. Rosado said that this was not a plausible explanation. Many children play or sleep with toys and do not develop bruises, particularly not around the eye. Also, M.M.'s bruises were in three different planes. Dr. Rosado concluded to a reasonable degree of medical certainty that M.M.'s bruises were non-accidentally inflicted.

¶ 28 On cross-examination, Dr. Rosado stated that he did not personally observe M.M.'s protective reflexes, but M.M. had no neurological deficits, so his reflexes should be normal. He admitted that a child in M.M.'s condition (weak, underweight, and dehydrated) would likely have slower reflexes than a healthy child. Although M.M. was borderline anemic and had a history of anemia, Dr. Rosado stated that being anemic does not cause an individual to be more susceptible to bruising.

¶ 29 Dr. Rosado also opined to a reasonable degree of medical certainty that M.M.'s failure to thrive was caused by both organic and non-organic factors. He based this conclusion upon M.M.'s growth chart, which was admitted into evidence. From birth to nine months of age, M.M. was "growing very nicely" in terms of his own growth curve. From 9 to 16 months, approximately the time that M.M. was at home with L.T., there was an "almost complete arrest of growth." After M.M. was admitted to Lurie in October 2013, his growth curve "start[ed] becoming more normal." Dr. Rosado concluded that if L.T. had followed M.M.'s feeding regimen, "he should [have] been growing like he was growing when he was in the hospital with the same regimen, and the same way that now he's growing after he was discharged somewhere else."

¶ 30 On cross-examination, Dr. Rosado said that he could not apportion what percentage of M.M.'s failure to thrive was organic as opposed to non-organic. He opined that even without the non-organic failure to thrive, M.M. would still have been hospitalized: "[H]e was still losing weight. So we needed to find out the reason why he was losing weight." But he maintained that M.M.'s failure to thrive was mixed in origin, stating, "M.M. was growing fine only with his G-tube and his PO intake and then he stopped growing and now he's growing again fine."

¶ 31 Finally, regarding the allegations of medical neglect, Dr. Rosado stated that from what he heard, M.M. had not been well for a few weeks prior to his admission to Lurie in October 2013. The day before his admission, a nurse at L.T.'s house asked L.T. to take him to the hospital and L.T. refused. She did not take him to the hospital until she was asked to do so by the nurse's supervisor. Dr. Rosado conceded that this delay "probably didn't make much of a difference."

¶ 32 Nurse Tierney's Testimony

¶ 33 Shawn Tierney is a nursing supervisor for Pediatric Services of America Healthcare (PSA), an agency assigned to provide in-home nursing services for M.M. via Illinois' Department of Specialized Care for Children (DSCC). M.M.'s case was approved for up to 98 hours of in-home nursing per week. PSA nurses were assigned to monitor M.M.'s TPN line and his G-tube, as well as provide day-to-day care such as bathing and diaper changing. They were not assigned to weigh M.M.; that was L.T.'s responsibility. As a supervisor, Tierney visited L.T.'s house once a month when M.M. had his TPN line, and then once every 60 days when it was removed.

¶ 34 On September 2, 2013, Tierney made a note that L.T. did not understand the fragility of M.M.'s condition and the importance of following doctors' orders regarding what he could and could not eat. On various occasions, Tierney found baby cereal, Gerber baby food, juice, and bottled milk in M.M.'s room—none of which M.M. was allowed to eat. M.M. was the only child in the house. When Tierney found these foods, she told L.T. that she was not supposed to feed them to M.M..

¶ 35 From October 6 to October 17, no nursing was provided for M.M. because DSCC incorrectly determined that he was no longer eligible for nursing hours. This issue was resolved and nursing resumed on October 18. On October 21, Tierney received a call from the on-duty

nurse, Maxine Doss. Doss said that M.M. looked thin and sickly; Doss asked L.T. to take M.M. to the hospital, and L.T. agreed. But when Doss visited again on October 23, L.T. had not done so.

¶ 36 After her October 23 visit to L.T.'s house, Doss again called Tierney. As a result of that call, Tierney spoke to L.T. and arranged to come to her home the next day. Tierney described M.M.'s condition during that visit as "[h]orrible." "He was very thin," said Tierney. "I could see his ribs. His stomach was swollen. His legs and arms were very skinny. His color was ashen. He had no smiles, made no noises, which is the complete opposite of what M.M. had been." At the request of Dr. Cohran's office, she brought a scale to weigh M.M. and found that he had lost several pounds. Tierney also observed bruises on M.M.'s right eye and cheek. She asked L.T. how he received those bruises, but L.T. would not answer. Overall, Tierney concluded that M.M. was not being properly cared for in L.T.'s home, since he was not being fed properly and not being brought to see doctors as scheduled.

¶ 37 Nurse Doss's Testimony

¶ 38 Doss is a registered nurse and works for PSA. She provided day-to-day care for M.M. from early 2013 until August 27, 2013, when L.T. informed her that L.T.'s husband would be taking over M.M.'s care.

¶ 39 Doss next provided nursing services at M.M.'s house on October 21, 2013. On that visit, M.M. appeared thin, with bruises on his cheek. He was sleepy, did not move around, and "just wasn't himself." Doss was concerned about his condition and asked L.T. to take him to the doctor that night. L.T. agreed to do so. When Doss asked about the bruises on M.M.'s cheek, L.T. said that he might have slept on a toy.

¶ 40 On October 23, Doss worked another shift at L.T.'s house. M.M.'s condition had not improved; he was still tired and weak, unable to hold his head up, and he did not move or play with any toys during the nine hours that Doss was there. L.T. said that she had not taken him to the hospital, though she "was going to"; she gave no explanation for the delay. By this time, Doss was very concerned. She said that M.M.'s lethargic behavior was similar to a previous incident when he had to be hospitalized because of vomiting and diarrhea.

¶ 41 L.T.'s Testimony

¶ 42 L.T. testified that M.M. was born at Mt. Sinai Hospital on July 12, 2012. His doctor at Mt. Sinai was of the opinion that M.M. would die from consequences of long-term TPN before he would be old enough to have a bowel transplant; thus, the doctor was not willing to do anything to try and save his life. L.T. sought a second opinion. She researched different hospitals and spoke with a social worker at Lurie about their resources for treating a child with short bowel syndrome. Eventually she and Tabitha decided to have M.M. transferred to Lurie.

¶ 43 Initially, Tabitha was actively involved in making medical decisions for M.M.. But after an incident where she stole a cell phone from a Lurie staff member, she was barred from entering the hospital. Because of that, Tabitha, L.T., and L.T.'s husband agreed that it would be best for L.T. to become M.M.'s legal guardian. She officially became his guardian on February 12, 2013.

¶ 44 M.M. was released to L.T.'s care on March 18. Before M.M. was released, L.T., her husband, her sister, and her daughter Shirlene all participated in a training program at the hospital where they learned procedures for taking care of M.M.. They received additional support from DSCC. According to L.T., she was not required to call Lurie with updates about

M.M.'s condition. Rather, on a weekly basis, a nurse from Walgreens Infusion Services would visit her house to weigh M.M., draw blood, and report the results to Lurie.

¶ 45 When M.M. was first released from the hospital, he was not yet having oral feedings, and L.T. was not given any instructions on how to feed him. Around May or June, Dr. Cohran's team began to encourage oral feedings. According to L.T., Dr. Cohran's team told her to avoid high-sugar foods and dairy products, but they did not give her any more specific guidance. In particular, they said nothing about avoiding juice. L.T. gave baby juice to M.M. two or three times a week, but she diluted it with water in a 50-50 ratio "to be safe" because she was not sure how much sugar the juice contained. She denied that M.M. experienced any adverse reaction to the juice. During clinic visits, she would tell Dr. Cohran's team what she was feeding M.M., including juice, and they never told her to stop giving him juice.

¶ 46 In July, L.T. brought M.M. to Almost Home for three or four days because she was sending her daughter to college. L.T. informed M.M.'s in-home nurses about this placement, but she did not inform Dr. Cohran's office, since M.M. did not have a clinic visit scheduled during those dates. Regarding allegations that Dr. Cohran's team was unable to contact her in July, L.T. said that a social worker from Lurie attempted to call her about an abnormal lab result, but the social worker did not leave a voice mail, so L.T. was unaware of it. Around the same time, L.T.'s car broke down, causing her to miss one of M.M.'s appointments at Lurie. Because of these events, the social worker made "a hotline call" (presumably to the DCFS hotline). The evening after the hotline call, as soon as L.T.'s car was repaired, she brought M.M. to the emergency room so that he could get his labs done. She was frustrated that the social worker had made a hotline call without knowing why she missed the appointment, and she explained the situation with her car to the social worker and Dr. Cohran's entire team.

¶ 47 In late July, M.M. was hospitalized, though L.T. could not recall the reason why. M.M. was released from the hospital on August 14 with his TPN line removed. Dr. Cohran told L.T. that when children are taken off TPN feedings, they typically lose around 10 to 15 percent of their body weight, but they later regain it. Upon M.M.'s release, a social worker asked L.T. to sign a medical agreement because she had missed a clinic appointment in July and they had been unable to contact her by phone. The agreement contained the same restrictions on M.M.'s diet as before, *i.e.*, no high-sugar foods or dairy products. L.T. again denied being given any more specific instructions about what foods to avoid. The agreement also provided that L.T. should weigh M.M. weekly and report his weight to Dr. Cohran's office. (Walgreens, which had previously been in charge of weighing M.M., was no longer involved with him because of the removal of his TPN line.) L.T. complied with this requirement. Because she only had an adult scale at home, she would typically weigh him either during her biweekly visits to Dr. Cohran's office or during visits to M.M.'s pediatrician, Dr. Amin.

¶ 48 On September 23, L.T. brought M.M. to see Dr. Cohran's team at Lurie, and they said that he was doing well. She admitted that during the first two weeks of October, she did not report M.M.'s weight. During the first week, Dr. Cohran was on vacation and unreachable; during the second week, when L.T. called Lurie, M.M.'s usual nurse practitioner was not available. L.T. did not leave any messages for them and was unsure if it was possible to do so. She did not think her lack of reporting was a problem, because she took M.M. to see Dr. Amin on October 15, and Dr. Amin did not raise any concerns about M.M.'s condition. At the time, M.M. was having issues with diarrhea. L.T. reported this to Dr. Amin, who suggested feeding M.M. different foods and putting his formula in his bottle for him to drink.

¶ 49 Dr. Amin's notes for M.M.'s checkups were introduced into evidence. The notes show a trend of weight loss: M.M. weighed 17 pounds at his July 9 checkup, 16.5 pounds at his September 17 checkup, and 15.6 pounds at his October 15 checkup. For the July 9 visit, Dr. Amin noted that M.M.'s "mom" (presumably L.T.) was constantly on her smartphone, even though Dr. Amin asked twice that she put it away. After taking M.M.'s vital signs, Dr. Amin asked "mom" to stay close to the table to watch M.M.; she held M.M.'s hand but continued browsing her phone. For M.M.'s October 15 visit, Dr. Amin noted that M.M. had a low-grade fever and was not eating well. She described his general appearance as "alert, comfortable, in no acute distress, pleasant, well hydrated, good colour, very quiet, cooperative."

¶ 50 L.T. did not have any concerns about M.M.'s health until October 23, when M.M.'s in-home nurse, Doss, called L.T. at work to inform her that M.M. had been vomiting and experiencing diarrhea. L.T. left work and called Lurie. M.M.'s regular nurse practitioner was not available; the nurse that was filling in for her instructed L.T. to give M.M. extra Pedialyte, which she did. She denied that Doss ever told her to take M.M. to the hospital.

¶ 51 The next day, October 24, PSA nursing supervisor Tierney came to her house with a weighing scale. Tierney weighed M.M. and reported to Lurie that he had lost four or five pounds. The nurse practitioner at Lurie then called L.T. and asked her to bring M.M. to the hospital. L.T. brought him later that day.

¶ 52 Regarding the bruises on M.M.'s face, L.T. testified that she never punched, slapped, or struck M.M. in any way. No further testimony was elicited about the source of the bruises.

¶ 53 Nurse Dailey's Testimony

¶ 54 Barbara Dailey provided day-to-day care for M.M. from August to October 2013. She was typically at his house two or three days a week and worked 10 to 12 hours each shift. She

would perform his assessments, check all of his medical equipment, monitor his progress, and administer his medication. She had no concerns about M.M.'s surroundings or the care he received from L.T.

¶ 55 Dailey was present "as a friend" on October 24, 2013, when L.T. took M.M. to Lurie. On that date, M.M. appeared normal; he was active and verbal, and his eyes were clear. Dailey did not notice any bruises on his face. On the previous weekend, Dailey saw an oval-shaped bruise on M.M.'s cheek, the same shape as the mouthpiece on his sippy cup. L.T. explained to her that M.M. fell asleep on his sippy cup in his crib. The bruise did not cause Dailey to be concerned that M.M. was being mistreated. Dailey was unable to identify the oval-shaped bruise on the photographs of M.M. taken at the hospital.

¶ 56 Regarding M.M.'s diet, Dailey stated that L.T. would feed him formula and "regular food that they ate." On cross-examination, she stated that she was not aware that L.T. had signed a medical agreement prohibiting her from giving M.M. high-sugar foods or milk products. Dailey admitted that she gave juice or fruit punch to M.M. on several occasions; the juice or punch was provided by L.T. and was always watered down. Towards the end of the time that Dailey was caring for M.M., he was suffering from significant diaper rash and diarrhea.

¶ 57 Trial Court Findings

¶ 58 The court issued its adjudicatory ruling on October 15, 2014. It found that the following expert opinions of Dr. Cohran and Dr. Rosado were unrebutted: (1) M.M.'s bruises were caused by intentional injury; (2) M.M.'s failure to thrive was partially non-organic; and (3) M.M. was medically neglected. The court further found that there was no evidence or justification to ignore the competent medical testimony of the doctors, particularly since it was consistent with Dr. Amin's notes. The court concluded that M.M. was both abused and neglected, in that he was

subjected to an injurious environment and not properly cared for. The court stated that although L.T. attempted to properly take care of M.M., "the demands of his care were simply more than she could adequately provide." With regard to M.M.'s bruises, the court explicitly declined to make any finding as to the perpetrator.

¶ 59 At a dispositional hearing on July 7, 2015, the court found that L.T. was fit, willing, and able to care for, protect, and train M.M. The court also found that M.M.'s mother was unable and unwilling to care for him, while his father was unable. Accordingly, the court made M.M. a ward of the court and returned him to L.T.'s care, over the objections of the State and the public guardian, under an order of protective supervision pursuant to section 2-24 of the Juvenile Court Act of 1987 (Act) (705 ILCS 405/2-24 (West 2012)). L.T. timely appealed.

¶ 60 ANALYSIS

¶ 61 L.T. argues that the evidence presented at the adjudication hearing was insufficient to support the trial court's findings that M.M. was neglected and abused, and she asks this court to reverse those findings. She also asks this court to reverse the dispositional order and the section 2-24 order of protective supervision.

¶ 62 In assessing L.T.'s claims, we are mindful that under the Act, the State bears the burden of proving neglect and abuse by a preponderance of the evidence. *In re K.T.*, 361 Ill. App. 3d 187, 200 (2005) (citing 705 ILCS 405/1-3(1), 2-21 (West 2002)). On appeal, we will not disturb the trial court's findings of neglect and abuse unless they are contrary to the manifest weight of the evidence, meaning that the record clearly demonstrates that the court should have reached the opposite result. *Id.* at 201. Such deference is warranted because the trial court is in a much better position to observe the witnesses and assess their credibility. *In re T.B.*, 215 Ill. App. 3d 1059, 1062 (1991).

¶ 63 Neglect Due to Non-Organic Failure to Thrive

¶ 64 Under Illinois law, neglect is defined generally as the failure to exercise the care that circumstances justly demand. *In re Erin A.*, 2012 IL App (1st) 120050, ¶ 6. It encompasses both intentional and unintentional disregard of parental duties. *Id.* The trial court found that M.M. was neglected under two sections of the Act: first, under section 2-3(1)(a), he was not receiving the support, medical, or other remedial care necessary for his well-being, and second, under section 2-3(1)(b), his environment was injurious to his welfare. 705 ILCS 405/2-3(1)(a), (b) (West 2012).

¶ 65 The trial court's first reason for its finding of neglect was that M.M.'s doctors diagnosed him with non-organic failure to thrive. The Act provides that a medical diagnosis of failure to thrive is *prima facie* evidence of neglect (705 ILCS 405/2-18(2)(b) (West 2012)). This presumption may be rebutted by other evidence (*In re Edward T.*, 343 Ill. App. 3d 778, 795 (2003)), but the court may not disregard expert medical testimony that has not been controverted by other competent medical testimony or medical evidence. *In re Ashley K.*, 212 Ill. App. 3d 849, 890 (1991); *In re Juan M.*, 2012 IL App (1st) 113096, ¶ 59.

¶ 66 Under this standard, the trial court's finding was not against the manifest weight of the evidence. Dr. Cohran testified that, although short bowel syndrome can cause weight loss (*i.e.*, organic failure to thrive), L.T.'s actions also contributed to M.M.'s weight loss in multiple ways. First, L.T. persisted in giving juice to M.M., although high-sugar foods were banned from his diet and Dr. Cohran specifically warned her against juice on multiple occasions. Children with short bowel syndrome cannot break down high-sugar foods, and ingesting such foods can cause diarrhea and weight loss. Second, M.M. experienced vomiting and diarrhea for two weeks prior to his October 24 admission to Lurie. During that period, L.T. did not call in M.M.'s weight (in

violation of the medical agreement she signed) or notify medical staff of his condition, which delayed his treatment and caused him to lose additional weight.

¶ 67 Dr. Cohran's testimony is corroborated by M.M.'s growth chart, which shows steady growth from birth until nine months of age (April 2013), an "almost complete arrest of growth" until October 2013, and then resumption of steady growth for the next two months, at which point the chart ends. The period of time where M.M.'s growth ceases its upward trend is nearly the same as the period during which L.T. was responsible for M.M.'s care, *i.e.*, March to October 2013. Based upon this evidence, as well as Dr. Cohran's testimony, the trial court did not err in finding neglect based on non-organic failure to thrive.

¶ 68 L.T. argues that M.M.'s weight loss was solely due to the removal of his TPN in late July. This assertion is unsupported by the medical evidence presented at trial. On the contrary, Dr. Cohran directly stated that M.M.'s TPN removal was not the sole cause of his weight loss. She testified that when M.M.'s TPN was first removed, while he was still in the hospital, he was gaining weight. It was only after he was discharged to L.T.'s care that he experienced the weight loss that ultimately led to his October 24 hospitalization.

¶ 69 L.T. also argues that Dr. Rosado's opinion regarding M.M.'s failure to thrive should be disregarded because it was based upon multiple inaccurate factual assumptions. See *Soto v. Gaytan*, 313 Ill. App. 3d 137, 146 (2000) (expert's opinion is only as valid as the bases and reasons for the opinion). In particular, Dr. Rosado seemed to be unaware that M.M.'s TPN feedings were discontinued in July, or that M.M. was placed back on TPN when he was hospitalized in October. This is evidenced by his statement that "M.M. was growing fine only with his G-tube and his PO [oral] intake and then he stopped growing and now he's growing again fine." Additionally, Dr. Rosado stated that if L.T. had followed M.M.'s feeding regimen,

"he should [have] been growing like he was growing when he was in the hospital with the same regimen, and the same way that now he's growing after he was discharged somewhere else." This is contradicted by Dr. Cohran's testimony that when M.M. was admitted to Lurie in October, he did not gain weight under the feeding regimen that he was supposed to have received under L.T.'s care, which is why his TPN was re-inserted.

¶ 70 We agree that Dr. Rosado's testimony regarding the cause of M.M.'s failure to thrive is, at best, questionable because of his misunderstanding of the facts. But Dr. Cohran, as M.M.'s primary care physician, was fully apprised of the facts regarding M.M.'s diet and his condition, and her testimony about the cause of M.M.'s failure to thrive remains unrebutted by competent medical evidence. Her expert testimony alone is sufficient to sustain the trial court's finding that M.M.'s failure to thrive was at least partially caused by L.T.'s failure to properly care for him.

¶ 71 Neglect Due to Medical Neglect

¶ 72 The trial court's second reason for its finding of neglect was its conclusion that L.T. medically neglected M.M.. L.T. argues that the evidence shows she did everything medically necessary to care for M.M., she did not unreasonably delay his clinic and hospital visits, and there is no nexus between her alleged neglect and M.M.'s hospitalization in October 23. Although there was conflicting evidence on these subjects at trial, we find that the trial court's conclusion was not against the manifest weight of the evidence.

¶ 73 A child is neglected if he does not receive appropriate medical evaluations or care. *Erin A.*, 2012 IL App (1st) 120050, ¶ 7 (citing *In re Stephen K.*, 373 Ill. App. 3d 7, 20 (2007)). Moreover, a child's condition need not be life-threatening in order for a court to enter a finding of neglect. See *In re N.*, 309 Ill. App. 3d 996, 1007-08 (1999) (upholding finding of medical neglect for premature infant where parents failed to follow up on medical evaluations; infant's

conditions were not life-threatening but had potential to create lifelong problems for him). Thus, for instance, in *Stephen K.*, 373 Ill. App. 3d at 21, this court upheld a finding of medical neglect for a minor with cystic fibrosis where the minor's parents missed medical appointments, did not listen to his doctor's recommendations, and did not follow up with recommended agencies.

¶ 74 In M.M.'s case, if we accept the State's witnesses as credible, which the trial court apparently did, the following scenario emerges: M.M. has a very strict diet and medical care plan. Close monitoring of his condition is crucial because any deviation from the norm can quickly cascade into a life-threatening situation. Additionally, Dr. Cohran needed to remain in close contact with L.T. so that she could adjust M.M.'s formula or feeding schedule as needed. Because of these concerns, Dr. Cohran's team signed a written medical agreement with L.T. in August 2013. L.T. agreed to call in M.M.'s weight on a weekly basis and bring him for biweekly clinic visits. She also agreed not to give him milk products or high-sugar foods, including juice.

¶ 75 Notwithstanding this agreement, L.T. continued to give M.M. juice, albeit diluted with water. She missed clinic appointments in October and also did not call in M.M.'s weight. L.T. testified that Dr. Cohran and the nurse practitioner were not available when she called, but she did not attempt to leave any messages for them, even as M.M. experienced vomiting and diarrhea in the two-week period prior to his rehospitalization. By October 21, M.M. was thin, lethargic, weak, and unable to hold his head up – the opposite of his usual cheerful, active self. Doss asked L.T. to take M.M. to the hospital, but she did not. She did not take him until three days later, when Tierney weighed M.M. and found that he had lost several pounds. Dr. Cohran characterized M.M.'s weight loss as significant and attributed it, in part, to L.T.'s failure to

report M.M.'s problems in a more timely manner. In light of this testimony, the trial court's finding of medical neglect was not against the manifest weight of the evidence.

¶ 76 L.T. argues that M.M. could not have been medically neglected because she brought him to see medical doctors on four occasions between his release on August 14 and his rehospitalization on October 25. Specifically, she brought him to Lurie twice (on August 28 and September 23) and to his pediatrician, Dr. Amin, twice (on September 17 and October 15). For a normal, healthy child, this would have been more than sufficient. But M.M. was far from a normal child. His special needs required his caregiver to remain in weekly contact with Dr. Cohran's team, for whom his pediatrician was not a proper substitute.

¶ 77 We do not mean to suggest that L.T. did not care about M.M., or that she did not make efforts to attend to his medical condition. Indeed, the record reflects that M.M. is alive today because L.T. refused to accept his original prognosis, actively sought a second opinion, and pursued further treatment. Yet, as the evidence demonstrates, L.T. did not fully grasp the fragility of M.M.'s condition. Under the circumstances, her failure to follow doctors' orders, as set forth in the medical agreement she signed, constituted medical neglect.

¶ 78 Abuse

¶ 79 L.T. next challenges the trial court's finding that the bruises on M.M.'s face were the product of abuse.

¶ 80 The trial court found that M.M. was abused under section 2-3(2)(ii) of the Act, which provides that a minor is abused if a parent, immediate family member, or any person responsible for the minor's welfare "creates a substantial risk of physical injury to such minor by other than accidental means which would be likely to cause death, disfigurement, impairment of emotional health, or loss or impairment of any bodily function" (705 ILCS 405/2-3(2)(ii) (West 2012)).

The trial court based its finding of abuse on the testimony of Dr. Rosado, an expert in child abuse pediatrics. Dr. Rosado testified that children do not typically get accidental bruises on the face, because a child will reflexively protect his face if he falls or is going to hit something. He opined that M.M.'s reflexes were normal due to his lack of neurological deficits. He also found it significant that the three bruises on M.M.'s face were all in different planes, suggesting that they were caused by three separate impacts. Based upon this evidence, he opined to a reasonable degree of medical certainty that M.M.'s bruises were not accidentally inflicted. None of his opinions were rebutted during the adjudication hearing. See *Ashley K.*, 212 Ill. App. 3d at 890 (court may not disregard uncontroverted expert medical testimony).

¶ 81 L.T. nevertheless argues that Dr. Rosado's testimony should not be given any weight because he failed to take into account the possibility that M.M.'s condition made him more susceptible to bruising. We disagree. Dr. Rosado testified unequivocally that M.M.'s anemia would not cause him to bruise more easily. Nor is this directly contradicted by Dr. Cohran's testimony. Dr. Cohran said that short bowel syndrome, in and of itself, does not make individuals more susceptible to bruising. She stated that short bowel syndrome can cause nutrient deficiencies, which, in turn, can potentially cause individuals to bruise more easily, but she did not specify whether M.M. fell within this category. In any case, to the extent that there was disagreement on this issue, it was the province of the trial court to assess the witnesses' credibility and weigh the evidence. *T.B.*, 215 Ill. App. 3d at 1062. Since Dr. Rosado was an expert in child abuse pediatrics, and Dr. Cohran was not, it was not unreasonable for the trial court to give Dr. Rosado's testimony more weight on this subject.

¶ 82 L.T. also argues that Dr. Amin's records support a finding of no abuse, since Dr. Amin did not note any bruises on M.M. during his October 15 visit (or any other visit). This is

unpersuasive, since it does not preclude the possibility of abuse occurring between October 15 and Dr. Rosado's examination of M.M. on October 25. This is particularly true in light of Dr. Rosado's testimony that the bruise on M.M.'s eye was accompanied by swelling, making it more likely to be a recent bruise.

¶ 83 Finally, we note that the trial court's inability to determine the perpetrator of the abuse does not warrant a different result. An adjudicatory hearing does not focus upon whether the respondent abused the minor but, rather, whether the minor was abused at all. *Juan M.*, 2012 IL App (1st) 113096, ¶ 59 (affirming finding of physical abuse that was supported by medical testimony even where court could not determine which parent perpetrated the abuse); see also *In re R.G.*, 2012 IL App (1st) 120193, ¶ 35 (perpetrator of abuse "is of no particular consequence in an adjudicatory hearing"). Thus, even if L.T. was not the perpetrator, that would not undermine the trial court's finding that M.M.'s bruises were not accidental.

¶ 84 Dispositional Order

¶ 85 In addition to challenging the trial court's adjudication of M.M. as an abused and neglected child, L.T. also asks this court to reverse the dispositional order making M.M. a ward of the court and implementing a section 2-24 order of protection. As she makes clear in her reply brief, her challenge to the dispositional order is premised solely on her argument that the court's adjudication findings were against the manifest weight of the evidence. Because we have found otherwise, we shall likewise not disturb the court's dispositional order.

¶ 86 CONCLUSION

¶ 87 The trial court's findings of neglect and abuse were not contrary to the manifest weight of the evidence. The evidence at the adjudication hearing showed that, although M.M. was a medically complex child, L.T. contributed to his failure to thrive by refusing to adhere to his

dietary restrictions, failing to keep in touch with the hospital in accordance with the medical agreement she signed, and unnecessarily delaying his hospitalization and treatment. Additionally, it was the unrebutted testimony of the State's expert in child abuse pediatrics that the bruises on M.M.'s face were intentionally inflicted. Accordingly, we affirm the adjudication of the trial court.

¶ 88 Affirmed.