Office of the Inspector General Report to the Governor and General Assembly (Jan. 2023)

OIG2023 #140

Child No. 140	**DOB: 11/2020**	**DOD: 02/2022**	**Natural**
Age at death:	14 months		
Cause of death:	Cerebral palsy and epilepsy; significant contributing conditions of viral upper respiratory tract infection, unsafe sleep environment (bed-sharing with blankets and pillows)		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-month-old was found unresponsive by his mother. The toddler had been diagnosed with cerebral palsy, a seizure disorder, hypotonia, obstructive sleep apnea, and was fed through a g-tube. The mother called 911 and began CPR. The toddler died in the ambulance enroute to the hospital. Shortly before the death, the parents had separated, and the mother had been staying with a friend and the friend's 3-year-old child for five days. The toddler had been sleeping on a nursing pillow in an adult bed with the friend and her 3-year-old child. The mother stated she regularly co-slept with the toddler, and she admitted to drinking the night before, but stated she had not been drunk. The child required oxygen for his sleep apnea, but first responders observed no oxygen tanks. Medical staff reported the toddler would have run out if he had been provided the oxygen as prescribed, and there was no record his oxygen had been refilled. The mother admitted she did not always provide the oxygen, and she did not take all of the toddler's medical equipment when she left the father's home. DCFS investigated the toddler's death and indicated his mother for death by neglect.

Reason for Review: In August 2021, law enforcement responded to a call that the toddler's 2-year-old paternal half-brother was found running around the neighborhood without supervision. At the time of the incident, the brother was in the care of his paternal grandmother, who stated the brother left the home while she was using the bathroom. The family installed a chain lock at the top of the door to prevent additional incidents. DCFS unfounded the paternal grandmother for inadequate supervision. In October 2021, DCFS received a report that the then 10-month-old was admitted to the hospital for seizures, and the father disclosed to hospital staff that the toddler had not taken some of his medication for a few days. Medical staff reported the toddler had missed three appointments in September 2021 and not seen his primary care doctor in over six months. Medical staff told the CPI the parents were observed to be appropriate with the toddler but did not appear to be educated on caring for his medical conditions. They also reported concern that the parents were not feeding him properly through his g-tube, as he was underweight. The mother told the CPI the toddler had been without two of his medications for approximately one month. The mother reported problems with transportation to the neurologist's office, which was three hours away, and they could not find one closer. Also, pandemic restrictions forced them to try and find childcare for their other children while they attended appointments. She stated they also had financial barriers in affording the toddler's specialized formula. The mother reported the toddler had weekly physical and developmental therapy at home. Two weeks after the Hotline report, the toddler was discharged from the hospital. In December 2021, the CPI met with the family at home, observed beds for each of the children, discussed safe sleep with the mother, and observed no marks or bruises on the toddler or his siblings. The mother reported the toddler had been doing well since re-starting his medication. She agreed to intact family services; a referral had been submitted, but the case had not yet opened at the time of the death. The investigation was unfounded for medical neglect.