pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Maura Graham

Date of Birth: 09/27/2007
Date of Death 11/26/2017
Date of Report to ChildLine: 11/28/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Northumberland County Children and Youth
Juniata County Children and Youth

REPORT FINALIZED ON:

5/16/2018

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Northumberland County Children and Youth has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/12/17.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	[redacted]	[redacted]1983
		[redacted]1980
Maura Graham	Victim Child	09/27/2007
[redacted]	[redacted]	[redacted]2015
		[redacted]2016
		[redacted]2006
		[redacted]2001
		[redacted]2012
[redacted]	[redacted]	incarcerated

* Not living in the home at the time of the incident

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families, CROCYF, obtained and reviewed the Northumberland County Children, Youth and Families, (NCCYF), [redacted] investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation.

Children and Youth Involvement prior to Incident:

The family was known to the agency prior to this incident. On 10/15/2010, the agency received a call [redacted] stating that [redacted] was [redacted] for imminent risk of sexual abuse on 9/17/2010 and the family was open for services 10/13/2010. The family relocated to Northumberland

County and remained open with them until the case was closed on 12/9/2010 due to the alleged perpetrator leaving the home and [redacted] completing services. On 6/11/17, the agency received [redacted] regarding [redacted] climbing out [redacted] 2nd story window to retrieve the family cat at 12:00 am. The [redacted] was [redacted] on 6/23/17. The family placed alarms on all the windows and the case was closed. On 10/20/16 a [redacted] was received alleging that [redacted] when [redacted]. This was [redacted] however the family was not opened for services. The hospital doctors and nurses were not concerned with [redacted] ability to care for the child. Upon [redacted], the intake worker made 1 announced and 1 unannounced visit to the home. There were no issues or concerns and the case was closed on 11/15/16.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 11/28/17 Northumberland County Children and Youth Services received [redacted] alleging the serious physical neglect of the victim child. The victim child is [redacted]. She presented at [redacted] on 11/26/17 for an evaluation of cardiac arrest. The child has a history of [redacted]. According to [redacted], the victim child was nauseated and vomiting at home prior to the emergency room visit. Upon arrival to the emergency room, the victim child was unresponsive and had several bruises on various locations of her body, which were not reported by the nurse. The victim child was developing increased edema of her legs and increased abdominal girth.

[redacted] transported the victim child to [redacted] in [redacted] truck because [redacted] felt that it would be quicker than the ambulance ride. [redacted] stated that she became totally unresponsive upon arrival to the hospital. The victim child died on 11/26/17 at 7:17pm at the hospital.

[redacted] stated that [redacted] called the child's physician earlier in the weekend because [redacted] had concerns that [redacted] was flaring. [redacted] said the physician recommended [redacted] because that has worked in the past for the child. [redacted] confirmed that the victim child was acting fine and doing chores with [redacted] until after dinner on Sunday 11-26-17.

Upon receipt of this referral it was learned from the [redacted] that [redacted] did not call the physician to alert anyone to the victim child's swelling. According to them, swelling of that nature does not occur in a short time. [redacted] also reported that the minor child did not receive medical treatment for a long period of time. It was also confirmed that the victim child's prescription medications were not filled since July 29, 2017. The medication needed was for [redacted]. She was prescribed [redacted]. [redacted] was very concerned because she did not have this medication for the past 4 months. The

child's last appointment with [redacted] was on March 13, 2017. All other scheduled appointments were no shows or cancellations. [redacted] never contacted Northumberland County Children and Youth regarding their concerns for the child's medical care.

[redacted] determined that the child died from cardiopulmonary arrest and complications from [redacted]. An autopsy was requested however the assistant coroner determined that it wasn't necessary based on the physicians determination for the cause of death and the victim child having a preexisting condition. The child was cremated prior to Children and Youth and [redacted] were notified of the death. Prior to her death, [redacted] had either cancelled or was a no show to [redacted] 10 times between 2015 and 2017. Again, this was never reported to Northumberland County Children and Youth.

There were [redacted] in the home at the time of the victim child's death. The family was accepted for services on 12/13/17. [redacted] were referred to [redacted]. Also the family was referred for [redacted]. [redacted] received [redacted] which resulted in 2 additional Childline numbers for [redacted].

[redacted] was put in place with [redacted] assuring the safety [redacted]. The [redacted] was [redacted] in Westmorland County.

[redacted] was [redacted] on 1/20/18 .[redacted] 2/21/18 and remain open for ongoing services.

<u>County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:</u>

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;

  The county agency investigation complied with regulations and response times as required.

- <u>Deficiencies in compliance with statutes, regulations and services to children and families</u>;

  No deficiencies were noted by the team regarding CYS compliance with statues, regulations, and services to [redacted]. The agency remains in compliance with safety and risk assessment regulations and was maintaining contact with [redacted] in accordance with the risk since the case was received on November 26, 2017.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

More education needs to be focused on training hospitals and ED departments on mandated reporting in a timely fashion. It needs to be noted to them that any suspicion of abuse or neglect is a reportable offense.

A policy for [redacted] and the performing of an autopsy to maintain any evidence that can be used in criminal prosecution need to be established.

More education needs to be focused on training hospitals and ED departments on mandated reporting in a timely fashion. It needs to be noted to them that any suspicion of abuse or neglect is a reportable offense.

A policy of [redacted] and the performing of an autopsy to maintain any evidence that can be used in criminal prosecution need to be established

Department Review of County Internal Report:

- The agency immediately began the investigation, cooperated with medical personal, and assured the safety of [redacted] involved.
- The agency conducted very detailed and thorough interviews with the subjects of the report, as well as collateral contacts. Decisions made on the case were well-informed.

Department of Human Services Findings:

- County Strengths:

  The county agency investigation complied with regulations and response times as required.

- County Weaknesses:

  The circumstances of this case and the review did not identify any systemic weaknesses. [redacted] was known to the agency and the agency responded appropriately to each referral received.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  There were none noted.

Department of Human Services Recommendations:

The Department concurs with the findings and recommendations of Northumberland County Children and Youth's Act 33 meeting.