



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

TYAIRA BROWN

Date of Birth: 06/02/2010

Date of Death: 09/11/14

Date of Oral Report: 09/15/14

FAMILY KNOWN to:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

9/17/15

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. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County has not convened a review team in accordance with Act 33 of 2008 related to this report. ChildLine received the report on 9/15/14 and it was determined to be [REDACTED] on 9/23/14.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Brown, Tyaira	Victim child	06/02/10
[REDACTED]	Mother	[REDACTED]/88
[REDACTED]	Stepfather	[REDACTED]/88
* [REDACTED]	Sibling/case child	[REDACTED]/11
* [REDACTED]	Non case child	[REDACTED]/02
* [REDACTED]	Caretaker/PGF	Adult
[REDACTED]	Caretaker/MGM	Adult
* [REDACTED]	Significant other of PGF	[REDACTED]/62
* [REDACTED]	Non -case Adult	[REDACTED]/93

*Not a household member

Notification of Child Fatality:

On 9/15/14 The Department of Human Services received a fatality report [REDACTED]. The child had [REDACTED], and died on 9/11/14. The mother previously attended a [REDACTED] Program at Children's Hospital of Philadelphia. The mother was instructed that when the child has a temperature of 100 degrees or higher, the child needs to be seen by a doctor immediately. The mother noticed the child had a fever with pain on the evening of Sunday 9/7/14. The mother gave the child some Ibuprofen for the pain, which also slightly reduced the fever. The mother brought the child to the Emergency Room on Monday evening, 9/8/14, when the child began decompensating. Dr. [REDACTED] determined the child's cause of death was enterovirus and parvovirus which led to her fever. The child's death was determined to be a fatality because the doctor felt that the child may have survived if she was transported and treated in the hospital prior to the child having a fever. The mother understood her daughter had [REDACTED] and there were certain precautions that the mother should adhere to.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. There was no Act 33 meeting because the allegation was determined to be [REDACTED] within 30 days of when the death occurred. There was no autopsy performed, and there was no police action taken.

Children and Youth Involvement prior to Incident:

On 4/23/11, there was a [REDACTED] Report to the Philadelphia Department of Human Services (DHS). This was the result of the mother testing positive for marijuana when [REDACTED] was born on [REDACTED] was not tested. A Safety Assessment was done at the home on 4/25/11. There were no present dangers identified. During the home assessment, it was noted that the banister from downstairs to upstairs was missing. This was a concern regarding [REDACTED] and coming home. The family agreed that [REDACTED] would reside in the home of his PGF and his wife until the banister was repaired. [REDACTED] was seen at the hospital on 4/23/11, and remained in the hospital on 4/25/11. The case was closed on 4/25/11 [REDACTED]

The mother and father had no involvement with DHS prior to the report listed above.

Circumstances of Child Fatality and Related Case Activity:

On 9/15/14 The Department of Human Services received a fatality report [REDACTED] Dr. [REDACTED] determined the child's death was a fatality. The doctor felt that the child may have survived if she was transported and treated in the hospital prior to the child having a fever. The mother understood her daughter had [REDACTED] and there were certain precautions that the mother should adhere to. The child had a 100 degree fever and the mother treated the child at home. On 9/8/14 the mother transported the child to the hospital. According to the attending doctor, the mother made a mistake when she didn't immediately transport the child to the hospital. [REDACTED]

The child died on 9/11/14. [REDACTED]

The child was born with [REDACTED], which left the child susceptible to [REDACTED]. The investigation, along with medical collaterals from CHOP, determined that the mother had no intent of causing the child's death. The mother has a history of compliance with the specialized medical care of the child. The report did not meet the CPSL criteria regarding medical neglect (resulting in physical condition).

Current Case Status:

There is currently an active case with [REDACTED]

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

There was no Act 33 meeting because the allegation was determined to be [REDACTED] on 9/23/14, which was within 30 days of when the death occurred. There was no autopsy performed, and there was no police action taken.

Department Review of County Internal Report:

The Department concurs with the county report's findings and recommendations. The county report was received on 9/15/14 and determined to be unfounded on 9/23/14.

Department of Public Welfare Findings:

- County Strengths:

The county conducted its investigation in a thorough and timely manner.

- County Weaknesses:

None

- Statutory and Regulatory Areas of Non-Compliance:

None

Department of Public Welfare Recommendations:

None identified.