



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## **REPORT ON THE FATALITY OF:**

**TALIA PARAVATI**

**Date of Birth: 11/15/13**  
**Date of Death: 3/31/14**  
**Date of Oral Report: 3/28/14**

### **FAMILY KNOWN TO:**

Montgomery County Children and Youth

### **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. Montgomery County has not convened a review team in accordance with Act 33 of 2008 related to this report. The allegation of abuse was determined to be [REDACTED] on 5/2/14.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Paravati, Talia	Victim Child	11/15/13
[REDACTED]	Mother	[REDACTED]/81
[REDACTED]	Father	[REDACTED]/84
[REDACTED]	Twin Sister	[REDACTED]/13
[REDACTED]	Sister	[REDACTED]/11
* [REDACTED]	Cousin	[REDACTED]/13
* [REDACTED]	Paternal Aunt	[REDACTED]/88
* [REDACTED]	Paternal Uncle	[REDACTED]/87

**Notification of Child (Near) Fatality:**

On March 28, 2014, Child came into the Pottstown Hospital via ambulance in cardiac arrest. The child was then transferred by helicopter to CHOP. Child was certified as a near fatality. Mother stated that this was the second time in a couple of weeks that the child had been in the ER. On March 3, 2014 child presented at the ER and was hospitalized for 3 days with [REDACTED]. The hospital reported that child was dead when she arrived. There was no medical explanation for the death. There was no visible trauma.

**Summary of DPW Child (Near) 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 upon receipt of the case record on April 2, 2014. Follow up interviews were conducted. There was no Act 33 Review. The case was determined to be [REDACTED] on 5/2/14 [REDACTED].

### **Children and Youth Involvement prior to Incident:**

**SERVICES PROVIDED:** There were 3 reports to Montgomery County Children and Youth

- December 20, 2012: Montgomery County received a report regarding [REDACTED]. The parents file separate reports of concern regarding the child's safety. A home assessment was completed; the family was not accepted for services.
- November 2013: This report was regarding Talia and her twin [REDACTED]. Mother [REDACTED] and the children remained in the hospital as they were born premature. It was reported that mother had limited visitation with children while they remained in the hospital. The county completed a safety assessment and determined there were no safety threats or concerns. The case was not accepted for service.
- March 4, 2014: GPS report. Montgomery County Children and Youth (C&Y) received a report that Talia presented at the Pottstown Hospital emergency room in severe respiratory distress. There was concern about negligence of the child. At this time the county was in the process of accepting the family for services.

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

On March 28, 2014, Child came into the Pottstown Hospital via ambulance in cardiac arrest. The child was then transferred by helicopter to CHOP. Child was certified as a near fatality. Mother stated that this was the second time in a couple of weeks that the child had been in the ER. On March 3, 2014 child presented at the ER and was hospitalized for 3 days with [REDACTED]. The hospital reported that child was dead when she arrived. There was no medical explanation for the death. There was no visible trauma. [REDACTED]

### **Current Case Status:**

There are two other children in the home. Talia has a twin sister [REDACTED] and there is a sibling [REDACTED]. Both of the children are with the paternal aunt and uncle, [REDACTED]. The children were medically assessed with a full skeletal examination. The examination determined that the children have no trauma. Safety plan is that mother has no unsupervised visitation; father can visit the children and assure that mother has no unsupervised contact with children.

### **County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

The County did not convene a review team for this report because it was determined to be [REDACTED] within 30 days.

**Department Review of County Internal Report:**

The Department concurs with the county report's findings and recommendations. The county report was received on 4/02/14, and was determined to be [REDACTED] on 5/2/14.

**Department of Public Welfare Findings:**

- County Strengths:

The documentation was thorough, citing all of the interactions with the supervisor, medical staff, and the Police department.

- County Weaknesses:

There were none identified.

- Statutory and Regulatory Areas of Non-Compliance:

There were none identified.

**Department of Public Welfare Recommendations:**

The Department recommends that the county continue to conduct thorough investigations and continue to provide their standard of excellence with regard to their documentation.