



**REPORT ON THE FATALITY:**

Yaniya Dwyer

**Date of Birth: 03/13/2015**

**Date of Death 05/15/2015**

**Date of Report to ChildLine: 05/21/2015**

**CWIS Referral ID#: [REDACTED]**

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE**

Philadelphia Department of Human Services

**REPORT FINALIZED ON:**

06/12/2016

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:**

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, 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.

Act 33 of 2008 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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 6/19/2015 [REDACTED]

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Dwyer Yaniya	Victim Child	03/13/2015
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2013
[REDACTED]	Father	[REDACTED] 1989
[REDACTED]	Mother	[REDACTED] 1988

**Notification of Child Fatality:**

[REDACTED]

On 05/15/2015, the victim child was brought to St. Christopher Hospital Emergency Room in cardiac arrest by the parents. Upon their arrival the infant was cyanotic without spontaneous respiration. A code blue was called and care was stopped after 45 min. Mother reports the victim child's symptoms began the day before. No outreach for care was made until the following day. [REDACTED]

**Summary of OCYF Child Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker and the Supervisor on May 21,

2015 and June 19, 2015. The regional office also participated in the County Fatality Review Team meeting on June 19, 2015 where copies of the medical examiner's reports and autopsy were presented.

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

On March 12, 2013, DHS received a [REDACTED] report alleging that the mother tested positive for marijuana when [REDACTED] was born and that the mother tested positive for marijuana throughout her pregnancy. The report was classified as a [REDACTED] report. This is the term used by this County when a birth mother is tested positive for illegal drugs. The mother reported that she smoked marijuana [REDACTED] and she stated that [REDACTED] father also smoked marijuana. [REDACTED] was born healthy and the mother appeared to be adequately prepared [REDACTED]. The mother and the father provided care for all of the children. The family was assessed and all of the children appeared safe in the home. DHS offered prevention services but the family declined. Mother, Father and the children are now residing together. The mother is employed and Father remains home with the children. The home is adequate. The sleeping arrangements are appropriate. There are no safety concerns. Parents demonstrated protective capacities to ensure the safety of their Children. [REDACTED] Services were declined the [REDACTED] report was closed effective 4/8/ 2013.

On May 16, 2015, DHS received a [REDACTED] report that provided notification of death. The mother transported Yaniya to St. Christopher's Hospital on May 15, 2015 after she noticed that Yaniya she was fatigued and appeared to not feel well. The mother had difficulty waking Yaniya from a nap. Yaniya was [REDACTED] St. Christopher's on May 4, 2015. She received [REDACTED] The report was rejected as there were no allegations of abuse or neglect.

**Circumstances of Child Fatality and Related Case Activity:**

On May 21, 2015, the Department of Human Services (PA DHS) received a [REDACTED] report alleging that two-month-old Yaniya died on May 15, 2015 [REDACTED] Yaniya was a medically fragile infant with several complex medical diagnoses [REDACTED]

After her birth, Yaniya [REDACTED] until March 28, 2015. Yaniya [REDACTED] to St. Christopher's from April 14, 2015 to May 4, 2015 for [REDACTED]

The family felt that they could provide adequate medical care [REDACTED] and agreed to follow up closely with outpatient care. As a condition of Yaniya's [REDACTED] the mother was advised to take Yaniya to a primary care appointment at [REDACTED] on May 7, 2015. The mother cancelled the appointment on May 7, 2015 due to an emergency with her son. There were no [REDACTED] appointments available until the following week so a pediatrician triaged

Yaniya's medical status. The mother was able to verbalize Yaniya's symptoms and care needs. Yaniya was assessed as stable. An appointment with [REDACTED] was scheduled for the following day so that Yaniya's [REDACTED] could be assessed. The mother brought Yaniya for her appointment on May 8, 2015, and Yaniya was assessed to be in stable health at that time. The [REDACTED] appointment was rescheduled for May 12, 2015. The [REDACTED] called the mother on May 11, 2015, to remind her of the appointment the following day, but the mother did not bring Yaniya for her appointment. Several outreach calls were made to the mother between May 12 and May 15, 2015, but the mother did not return any calls. On May 15, 2015, the mother brought Yaniya to St. Christopher's Hospital. Yaniya was in cardiac arrest. Resuscitation efforts were unsuccessful and Yaniya was pronounced dead. The mother noted that Yaniya had not been her usual self the day prior and stated that Yaniya was sleeping for longer periods of time and had to be awoken for feedings. Despite Yaniya's symptoms, the mother did not contact the pediatrician for a sick visit nor did she seek any medical guidance.

### **Current Case Status:**

[REDACTED] completed an additional interview with the mother. The mother showed them Yaniya's [REDACTED] and the documentation regarding Yaniya's [REDACTED] on May 4, 2015. The mother stated that she was told how to [REDACTED] but denied that she was given written instructions or provided with training. [REDACTED]

[REDACTED] The mother appeared to understand Yaniya's medical needs and her responsibilities as a caregiver.

The mother continued to deny that she was made aware of the May 12, 2015 appointment and stated that no one from St. Christopher's called her to report the missed appointment. The mother provided her telephone contact log and there did not appear to be any missed calls from St. Christopher's. Prior to Yaniya's death, the mother reported that she never thought Yaniya was in distress and she continued to give her [REDACTED]. The mother believed that Yaniya was sleeping longer than usual because she was still recovering from her previous illness. The mother reported that she did not observe any signs of distress, such as trouble breathing or coldness, until she checked on Yaniya at dinnertime. When the mother observed that Yaniya's lips were blue, they transported her to St. Christopher's. The father was unable to provide any information about the events of May 15, 2015, as he had been at work.

The Medical Examiner's Office determined that Yaniya's cause of death was natural and due to bacterial bronchopneumonia complicating rhinovirus infection. At the Act 33 meeting, the medical professionals on the Team noted that children with [REDACTED] do not have normal immune systems and that they can quickly become very ill.

On August 11, 2015, the [REDACTED] report was [REDACTED].

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

**Department Review of County Internal Report:**

The Southeast Region, Office of Children, Youth and Families received the County's Internal Report on September 16, 2015, and is in agreement of the County's findings.

**Department of Human Services Findings:**

- County Strengths: There was clear evidence of collaboration during the investigation between the county and other entities.
- County Weaknesses: NONE
- Statutory and Regulatory Areas of Non-Compliance by the County Agency

None

**Department of Human Services Recommendations:**

Although there were no deficiencies it will be prudent for the county to incorporate a mobile unit when dealing with families of sick children. This mobile unit should ensure that the parents are notified and brought to the critical clinic for scheduled or routine appointments.