pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Amaya Melendez

Date of Birth: March 4, 2011
Date of Death: July 16, 2013
Date of Oral Report: October 11, 2013

FAMILY KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

May 5, 2014

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 convened a review team in accordance with Act 33 of 2008 related to this report on November 8, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
Amaya Melendez	Victim child	[redacted]/2011
[redacted]	Sibling	[redacted]/2007
[redacted]	Sibling	[redacted]/2009
[redacted]	Sibling	[redacted]2013
[redacted]	Biological mother	[redacted]/1989
* [redacted]	Biological father	[redacted]/1989
[redacted]	Maternal grandmother	[redacted]/1957

*non-household member

Notification of Child Fatality:

On October 11, 2013, The Department of Human Services was notified that a child was unresponsive and was taken to the hospital on July 16, 2013 where the child died. The toxicology report stated that the child had a high level of [redacted] in her system. Mother reports that she gave child Tylenol which was also on the toxicology report. Mother did confirm that she was [redacted].

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. Follow up interviews were conducted with the CUA Supervisor. The regional office also participated in the DHS Act 33 Review Team meeting on November 8, 2013 where information pertaining to the amount of [redacted] the victim child actually ingested was disclosed and the dynamics of the family's history.

Children and Youth Involvement prior to Incident:

- On March 5, 2011, DHS received a [redacted] report stating that the mother tested positive for marijuana when the victim child was born. The report was investigated and a need for service was not established. The Child Abuse Prevention Treatment Act (CAPTA) unit completed a home assessment and the home appeared appropriate. The mother declined voluntary services.

- On September 29, 2011, DHS received a [redacted] report alleging that the mother was on drugs, sold her food stamps and the children did not have any food. In addition, the report alleged that the oldest child had head lice and the mother did not seek treatment. The mother would frequently leave the child with MGM who was in poor health. The assessment determined that the family was in need of services. The family received In-Home Protective services through [redacted] from November 2011 to May 3, 2012

- On February 28, 2012, DHS received a [redacted] report stating that the mother dragged the oldest child up and down the stairs by her hair. It was not clear whether or not the child was injured. It was also reported that the mother was an active substance abuser and she did not take care of the children. This case was already open with DHS and the family was receiving in-home services. The report was investigated and there were no additional findings. The case remained open with in-home services.

- On July 16, 2013, DHS received a [redacted] report providing information about the victim child's death. The mother found the victim child unresponsive and the police transported the mother and victim child to St. Christopher's Hospital where the victim child was pronounced dead. There were no signs of external trauma and the victim child appeared to be healthy. It was reported that the victim child had a well-baby check six weeks prior and was up to date with her immunizations. The mother had two other children and was pregnant with another child. This report was rejected due to no allegations of abuse or neglect.

- On July 19, 2013, DHS received another [redacted] report alleging that the mother gave the two oldest children [redacted] that was [redacted] to them. They were dirty and the home was deplorable. It was further reported that she left the children in the care of other people. It was reported that the victim child died [redacted] because the mother was aware that the victim child had a fever but the mother did not take her to the hospital. In addition, the report alleged that the mother took pills, smoked marijuana and had mental health issues. This report was also investigated and the allegations were [redacted]. The mother refused a referral for prevention services.

Circumstances of Child Fatality and Related Case Activity:

On October 11, 2013, the Department of Human Services was notified that the victim child was unresponsive and taken to the hospital on July 16, 2013 by police escort with the mother holding the victim child in her arms. They were taken to St Christopher's Hospital. On July 15, 2013, it

was noted that the victim child had a fever but there is no knowledge of the duration the victim child had the fever. The mother reported that she gave the victim child some Tylenol for the fever and gave her a bath. The mother laid the victim child down, went out for a while and upon returning, checked on the victim child and the victim child was not responsive. The maternal grandmother (whom the mother and children were residing with because the maternal grandmother did not feel well) called 911 but the mother could not wait and flagged down a police officer. The police officer transported the mother and victim child to St. Christopher's Hospital. At 12:35 am, the victim child was pronounced dead. It was later determined that she died due to an overdose of [redacted].

Due to the child's death, the mother was [redacted] for failing to supervise the victim child appropriately which resulted in the victim child ingesting the [redacted] medication. The toxicology report confirmed that the victim child ingested the equivalent of 10-11 pills.

Current Case Status:

- The mother continues to have supervised visits two days a week with her two youngest surviving children. The two children reside in kinship care.
- The oldest child resides with her biological father in New Jersey. Sibling visits [redacted] and CUA agency is in the process of setting up these visits.
- [redacted] remains an active/ongoing case. The mother was recently kicked out of a [redacted] due to non-compliance. However, the CUA agency continues to work with the mother.

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

- Strengths:

  The children's safety and well being were addressed by DHS in a timely manner. DHS was in compliance with statutes and regulations and sorted out inconsistencies of events which occurred.

- Deficiencies:

  There were no deficiencies identified.

- Recommendations for Change at the Local Level:

  There were no recommendations.

- Recommendations for Change at the State Level:

  There were no recommendations.

Department Review of County Internal Report:

The Department agrees with the findings of the Act 33 review. DHS conducted the review timely.

Department of Public Welfare Findings:

- County Strengths:

  The MDT SW conducted a thorough [redacted].

- County Weaknesses:

  There were no areas of concern identified.

- Statutory and Regulatory Areas of Non-Compliance:

  There were no areas of concern identified.

Department of Public Welfare Recommendations:

The Department should work with the Office of Mental Health and Substance Abuse Services to ensure that education is provided by behavioral health providers for parents who are prescribed narcotics about the need for safety around children.
Information should be included in the Safety Assessment process utilized by the county workers when evaluating families' homes. The county agencies should address with the parents the need for safe storage of prescription medications in the home.