



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

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

**TONIYA ANDERSON**

**Date of Birth: 4-15-2014**  
**Date of Incident: 6-1-2014**  
**Date of Oral Report: 06-1-2014**

### **FAMILY KNOWN TO:**

**Chester County Children and Youth Agency**

**REPORT FINALIZED ON:**  
**December 29, 2014**

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 convened a review team on June 24, 2014 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Toniya Anderson	Victim Child	04/15/14
[REDACTED]	Mother	[REDACTED]/88
[REDACTED]	Brother	[REDACTED]/06
[REDACTED]	Sister	[REDACTED]/09
[REDACTED]	Father of [REDACTED]	[REDACTED]/82
[REDACTED]	Father of victim child	[REDACTED]/83
[REDACTED]	Father of [REDACTED]	[REDACTED]/63
[REDACTED]	Paternal GM of [REDACTED]	Unknown

**Notification of Child Fatality:**

On June 1, 2014, Chester County DCYF received a [REDACTED] report [REDACTED] due to a child fatality. The reason was [REDACTED] alleging that the victim child (6 weeks old) had suffocated, by mother's admission, as a result of mother's impaired judgment due to alcohol consumption. Mother, victim child and the victim child's brother were all sleeping in the same bed on the night of May 31, 2014. The mother woke up to find the victim child limp and not breathing; lying in the bed between herself and the victim child's brother.

**Summary of Southeast Region Child Fatality Review Activities:**

The South East Region Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the victim child's family from Chester County DCYF. This included the Multidisciplinary Team report, Risk Assessment, FSP and Police Report. SERO participated in the Act 33 Review on June 24, 2014 and collaborated with Chester County DCYF, the physicians and police.

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

The family became known to the Chester County, Department of Children, Youth and Families (DCYF) in 2009. The family was open and receiving [REDACTED] between 2009 and 2010 due to concerns regarding the mother's [REDACTED] issues and child supervision. The victim child's older sibling tested positive for cocaine at birth and this prompted services to be placed in the home. The mother struggled to [REDACTED]

[REDACTED] The services to the family included basic parenting skills and safe parenting practices; which included safe sleeping education.

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

The mother reported to the Chester County, Department of Children, Youth and Families (DCYF) that she had been residing at the [REDACTED] shelter for about a month, due to lack of housing. She reported going to a barbeque at a relative's house with the children on May 31, 2014. The mother stated that she had been drinking alcohol at the barbeque and returned to the shelter that evening and left the children in the care of another resident at the shelter and went to a nearby bar where she continued to consume alcoholic beverages until returning to the shelter. The mother stated that, when she returned to the shelter, she put the children to bed at about 2am. The mother stated that she has a pack n play for the victim child to sleep in but did not use it. The mother stated that she woke up about 2:30 or 3:00 am, fed the victim child and fell back to sleep. At about 7:00am, the mother woke up to find the victim child's sibling moving around in the bed and then she fell back to sleep. The sibling is [REDACTED] and likes to sleep in her bed. The mother stated that she woke up again at about 9:00 am and found the victim child laying in the bed limp and not breathing. The victim child was positioned between herself and the older sibling. The mother stated that she called 911.

After receiving the report, the county conducted a safety assessment to determine the mother's ability to care for the older sibling. The mother's ability was determined to be diminished due to the stress of losing her child and current living status. The mother was unable to continue residing in the shelter and had to leave. The county determined that the child was unsafe and developed a safety plan for the sibling to reside in a relative's home. After residing in the relative's home for 2 days, it was determined that the relative's home was not a viable resource. [REDACTED] and the sibling was placed into foster care through DCYF and then was moved into a [REDACTED] foster home which better met his needs. The mother [REDACTED] issues and [REDACTED]

The [REDACTED] on July 14, 2014 because it could not be determined that [REDACTED] alcohol consumption contributed to the victim child's death.

**Current Case Status:**



The county provided follow up with public and private stake holders from the onset of the [REDACTED] report and investigation.

- County Weaknesses:

None identified

- Statutory and Regulatory Areas of Non-Compliance:

None identified

**Department of Public Welfare Recommendations:**

The Department did not have any recommendations. DCYF completed safety visits, safety plans, interviews and collateral contacts as required. The County completed a thorough investigation