pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF

Aurora Heiney-Moore

Date of Birth: 11/21/2010
Date of Death: 04/21/2011
Date of Oral Report: 08/23/2012

FAMILY KNOWN TO:
Lancaster County Children and Youth Agency

REPORT FINALIZED ON: October 3, 2013

This report is confidential under the provisions of the Child Protective Services Law and cannot be released. (23 PA. C.S. § 6340)

Unauthorized release is prohibited under penalty of law. (23 Pa. C.S. § 6349(b))

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Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed into law on July 3, 2008 and went into effect on December 30, 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. Lancaster County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name	Relationship	Date of Birth
Heiney-Moore, Aurora	Victim Child	11/21/2010
[redacted]	Mother	[redacted]1984
	Father	1988
	Sibling	2006
	Sibling	2009
[redacted]	Maternal Grandmother	[redacted]1962 *Not in Home

Notification of Child Fatality:

This incident occurred on April 12, 2011. On that date the [redacted] contacted the agency to report the child fatality. The death was not seen to be suspicious and the cause of death was returned as "undetermined". This was not investigated by the agency as an [redacted] report.

On August 21, 2012, the Father was incarcerated for an unrelated incident. On August 22, 2012, the Father [redacted] was interviewed regarding this incident by the [redacted], which also included continued questioning regarding the death of the Victim Child, and stated that he laid on top of the Victim Child [Aurora Heiney-Moore] until she stopped crying which resulted in the Victim Child suffocating. The [redacted] contacted the agency with the information, stating that the Coroner's report would be amended to list the cause of death as homicide.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the Victim Child and her family. Conversations and interviews were conducted with the Caseworker [redacted], [redacted] Supervisor [redacted], and Intake Director [redacted] throughout involvement but specifically on the date of the report August 23, 2012 and when the [redacted] Decision was made on September 19, 2012. An interview was also conducted with [redacted] Director, [redacted] on April 10, 2013 for updated case information. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on August 28, 2012.

Children and Youth involvement prior to Incident :

The agency received a referral on the family in May 2009. The Mother [redacted] was allowing her daughter to visit with the child's father at a home where other household members had their children removed by CYS. The agency held a discussion with the Father about watching his children at

another residence as there were concerns with the current location. After this discussion, the case was screened out at intake, with no further services provided.

In October 2010, the agency received a referral from [redacted] the Lancaster Womens and Babies Hospital regarding the Mother. The Mother was pregnant with her third child, and had recently been missing prenatal appointments. The [redacted] was also concerned that the Mother had some drug use [redacted]. The [redacted] was planning to screen the Mother when she gave birth to her child, and would contact the agency when this occurred. This case was screened out, and there was no indication that the [redacted] contacted the agency when the child was born.

In November 2010, the agency received a referral from an anonymous person stating that the mother was still pregnant and living with her two children, and her paramour in the home of her mother, who may have custody of the two older children. The referent felt that the home was "crazy" and thought there were too many people living in the home. The agency inquired about the older children being in school and were told that they were in [redacted] was contacted and they reported no concerns with the children. They also discussed that they had been to the home and it was clean and there were no hazards that could be observed. The agency also had a phone conversation with the grandmother who reported that she has a two bedroom apartment and the Mother and children share the one bedroom. She also indicated that the Mother had given birth, and that she was looking for appropriate housing. The agency closed the case after receiving this information.

On January 31, 2011, the agency received a report regarding physical maltreatment of the Victim Child by an unknown perpetrator. The [redacted] making the referral had seen the child on January 28, 2011 and noticed [redacted] When the agency saw the child on January 31, 2011, there were no observable injuries. The agency conducted a full investigation including interviews of all parties. All interviewed denied any physical abuse. The agency could not substantiate any physical abuse, but noted ongoing concerns regarding domestic violence between the Mother and Father. The Mother also indicated that she wanted to move out on her own and care for her daughter. The agency conducted a home visit on March 30, 2011 and observed all children with no concern. The agency met with the parents on April 1, 2011 to discuss goals of the Family Service Plan. The Family Service Plan was being completed for review at the time that the report of the Victim Child's death was received.

Circumstances of child fatality and related case activity

This incident occurred on April 12, 2011. On that date, the [redacted] contacted the agency to report the child fatality. According to that report, the Father and Victim Child were sleeping on a futon. At 10:30 am, the father woke up and noticed the child was unresponsive. Emergency Services were contacted and noted that the Victim Child was deceased upon their arrival at the home. The child had [redacted]. There was no indication that these [redacted] were considered suspicious. An autopsy was scheduled for that week. At the time, the death was not seen to be suspicious and the cause of death was returned as "undetermined". This was not investigated by the agency as an [redacted] report.

On August 21, 2012, the Father was incarcerated for assaulting the mother. On August 22, 2012, the Father was interviewed by the [redacted] due to charges unrelated to the child fatality, though the [redacted] included questions regarding the child. In discussing the Victim Child, the Father stated that the Victim Child had been fussy and crying and he just wanted her to stop. He laid on top of her until she stopped crying which resulted in the Victim Child suffocating. The Father reported that he was upset with the child because she was crying. He reported that he "blacked out" and when he came to, "he was lying on top of the child and she was gone and stopped breathing." He further stated that he knew what he did was wrong and wishes he could take it back. The Father had stated that he felt his relationship would improve with the Mother if the Victim Child was out of the way. He stated that he had lied about falling asleep on the victim child because he did not want her mother to find out what really happened

and leave him. The [redacted] contacted the agency with the information, stating that the Coroner's report would be amended to list the cause of death as homicide. The father was arraigned on August 23, 2012 for Homicide and remained in [redacted] Prison without bail.

The agency immediately began a [redacted] investigation and the case was processed as a fatality. The family was already open for in-home services with the agency and the two older half-siblings of the victim child were living with the maternal grandmother who was able to supervise them. A safety plan was already in place from May 2012 when the agency had concerns about the mother's drug use. She had been minimally compliant with her family service plan and the grandmother was to supervise her around her children. The mother had indicated that she may give full custody of her children to the grandmother, but did not make any move to do so during the course of the investigation.

The agency completed the [redacted], filing the report [redacted] on September 19, 2012. The case was [redacted] as he confessed to smothering the child. The family remained open for in-home services with the agency. The two older children were still living in informal kinship care with the maternal grandmother.

Current Case Status:

Lancaster County CYA has continued to provide in-home services to the two older children. The two children reside full time with the maternal grandmother. The grandmother supervises all contact between the Mother and her children. The Mother continues to work minimally on her Family Service Plan. She is still expected to receive [redacted] and has not followed through. She is also transient, sometimes staying with the maternal grandmother, but often staying in other places with friends. The grandmother continues to discuss pursuing full custody of the children, and is attempting to save up the money to do so. The agency safety plan is no longer in place and the Mother is able to visit with her children at the grandmother's home. This continues to be an informal arrangement.

The Mother gave birth to a baby girl [redacted] on [redacted]. The Mother is currently providing full time care to this child with local supports in place. The CYA worker visits with her on a weekly basis. The Mother reports that the father of the child is currently [redacted]. The agency case remains open.

The Father was found Guilty of Murder of the Third Degree on August 27, 2013. He was confined at SCI [redacted] on September 13, 2013 with a minimum sentence of 20 years, maximum sentence of 40 years. The agency is in the process of filing the [redacted].

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on 09/12/2012 at the Lancaster County Children and Youth Agency. The team was comprised of local CYS professionals, medical professionals, law enforcement, and other community members. The Team discussed Lancaster County CYA's handling of the [redacted] Investigation and found it to be appropriate.

- Strengths
  The team felt that the agency handled the current [redacted] investigation well and provided information to all parties involved. It was also felt that the agency had been taking appropriate action with the family at the time of the Victim Child's death. They were opening the family for services and were in the process of getting supports in place to help the Mother.

- Deficiencies
  It was discussed that some of the earlier referrals were possibly closed too quickly by the agency. This was seen as something that could be addressed by the agency by looking at the screening process and determining if changes are needed to prevent premature screen-outs. The agency was praised by the team for seeking out information from collaterals, but this could always be improved to gather more information.

- Recommendations for Changes at the Local Level
  The team felt that the community could use more education for new and young parents, as well as more resources for those involved in domestic violence.

- Recommendations for Changes at the State Level
  No changes were identified by the team.

Department Review of County Internal Report:

Lancaster County CYA provided a report on the Fatality of the Victim Child to the Regional Office on October 9, 2012 after the investigation had been completed and the information compiled. The report contained all required information and had a summary of the findings of the Agency Act 33 Review Team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on June 18, 2013.

Department of Public Welfare Findings:

- County Strengths:
  County response to information received was urgent and thorough during the [redacted] investigation.
  The [redacted] Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
  The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.

- County Weaknesses:
  The MDT did not offer any suggestions for how this child fatality could have been prevented, but did feel that the agency possibly should have provided further follow up than just a phone call on some of the earlier referrals.

- Statutory and Regulatory Areas of Non-Compliance:
  All regulations regarding [redacted] investigations and subsequent county services were followed.

Department of Public Welfare Recommendations:

The agency should continue to assess their screening process and determine if response is sufficient for some concerns, especially those received from medical professionals.