pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Laina Haney

Date of Birth: 12/28/2006
Date of Incident: 10/31/2019
Date of Report to ChildLine: 11/01/2019
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Bedford County Children and Youth Services

REPORT FINALIZED ON:
05/04/2020

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:
Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Bedford County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 11/04/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Laina Haney	Victim Child	12/28/2006
[redacted]	Sibling	[redacted]/2003
	Mother	[redacted]/1979
	Father	[redacted]/1974
	Stepfather	[redacted]/1984
	Sibling's Paramour	[redacted]/2002

*Denotes an individual that is not a household member or did not live in the home at the time of the incident but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [redacted] Family. CERO staff reviewed various reports, assessments, and case documentation provided by Bedford County Children and Youth Services (BCCYS). CERO staff discussed the case with the county on 11/04/2019, 11/07/2019 and 12/17/2019.

Summary of circumstances prior to Incident:
Family was not known to BCCYS or other child welfare services prior to the incident.

Circumstances of Child Fatality and Related Case Activity:
On 11/01/2019, BCCYS received information from the [redacted] Police [redacted] regarding the murder of a child by [redacted] BCCYS subsequently made this report to ChildLine which was registered as a physical abuse and child fatality investigation. Information on the case is based on interviews of the [redacted] by both law enforcement and the BCCYS caseworker, and [redacted]

On 10/31/2019, the [redacted] woke up at 4:00am [redacted] and called off work. [redacted] reports that [redacted] then went to a local lake and sat there for a while, after which [redacted] purchased a 380 Taurus handgun from a local hardware store. The [redacted] then went home, slept for several hours and then picked up the victim child from school and took her home. When [redacted] arrived at the home, [redacted] were in the home. [redacted] stated that [redacted] asked the mother to come into the basement to discuss the fuel for the home. While [redacted] were in the basement, [redacted] shot [redacted] in the head. [redacted] then came upstairs, showed the [redacted] the gun and went outside to smoke a cigarette. [redacted] reports that the children asked [redacted] about the noise but [redacted] said it was from the neighbors. [redacted] did not recall hearing a noise when interviewed. While [redacted] was outside, the [redacted] left the home so that the [redacted] could go to work. The victim child was sitting on the couch and watching a movie while texting on her phone. The [redacted] reports that [redacted] then shot her in the head and moved her body to the basement. [redacted] then went to a local store and bought cleaning supplies, attempting to clean up the home. [redacted] waited for a couple hours at the home, with the intention of killing the [redacted] when they returned. However, [redacted] then called 911 and turned [redacted] in before [redacted] returned home. It was reported that the victim child was found in the basement with her pants and underwear pulled down. The [redacted] stated that this occurred when [redacted] dragged the child's body. The autopsy provided no information that any further abuse had occurred. The [redacted] did not report any trouble in [redacted] marriage or motive for killing [redacted] also stated that [redacted] remembered everything that happened and that [redacted] knew it was wrong. [redacted] was arrested and taken to [redacted] County Prison. The [redacted] went to [redacted] home.

BCCYS received medical records for the [redacted] which showed that [redacted] since June 2019. Two weeks prior to the fatality incident, the [redacted] There is no indication in the record that the [redacted] intended to harm [redacted] or others.

BCCYS interviewed [redacted] did indicate that the [redacted] was acting strange on the day of the incident, as [redacted] told them that [redacted] went for a walk and then left the home, which was odd since it was raining, and the victim child was still at the home. [redacted] reported no other problems in the home that could have led to the incident. [redacted] did agree to [redacted] to address everything that had happened regarding the incident. [redacted] was also helping [redacted] with the legal aspects of being responsible for the [redacted] home [redacted]

BCCYS filed their investigation report with ChildLine on 12/09/2019 with a status of [redacted] was named as the perpetrator as [redacted] admitted to shooting the child.

[redacted] is currently charged with two counts of murder of the first degree, two counts of criminal homicide, two counts of voluntary manslaughter and one count of tamper with/fabricate physical evidence. [redacted] remains incarcerated in at the [redacted] County Prison awaiting formal arraignment and trial. Bail was denied.

BCCYS closed their case with the family and the end of the investigation as the [redacted] is residing with [redacted] and no additional services were needed for the family.

A scholarship fund was established in the name of the victim child by family and friends, with proceeds benefitting individuals in a local rifleman club, where the victim child had been an active member.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  - The 911 operator remained calm and was able to get the gunman to disarm [redacted]
  - Fire, EMS and other first responders provided support for [redacted] and was careful to make sure the scene and evidence remained intact.
  - [redacted] provided additional personnel to support the lead investigator.
  - [redacted] chaplain provided support to the troopers as well as the family.
  - The District Attorney was on scene and at the [redacted] to ensure reports and search warrants were expedited appropriately and in a timely manner.
  - CYS's response to the family was immediate, compassionate and patient.
  - The school district ensured immediate [redacted] to faculty, staff and students by enlisting the assistance of the [redacted]
  - Those who responded to the scene worked continuously overnight and into the next day to ensure the investigation was being processed in a timely and thorough manner.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - An individual on the scene should have made a ChildLine report. Our team recognizes the need for an individual to be responsible for this report and have discussed this concern in the past. We will discuss roles and responsibilities of all involved agencies to rectify this issue.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - The county agency report did not mention any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
    - The county agency report did not mention any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - There will be a [redacted] available at the viewings to provide emotional support.
    - The District Attorney, [redacted] and victim services will meet with the family prior to the preliminary hearing.
    - Discussion to be had at MDIT regarding a candlelight vigil.
    - The team will meet again, prior to Christmas, to debrief and provide updates.

Department Review of County Internal Report:

The Central Region Office received the Bedford County Child Fatality Team Report on 11/07/2019. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 11/04/2019. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Bedford County Administration on 11/07/2019.

Department of Human Services Findings:

- County Strengths:
    - Upon receiving the information regarding the incident, BCCYS responded immediately and collaborated with law enforcement and other professionals on the case.
    - The county immediately gathered their team for review of the circumstances and to plan on community response to the incident.
    - The agency Act 33 team was comprised of pertinent individuals that could provide valuable input and history of the family.
    - The agency completed an appropriate investigation while providing compassionate support to those family members impacted by the loss of their loved ones.
- County Weaknesses:
    - The Department concurs with the weakness discussed by BCCYS in their internal Act 33 report. One of the first responders to the scene of the incident should have reported the fatality to the ChildLine hotline. The agency team has recognized this as a concern and will continue to address this with their local team of responders.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - No areas of non-compliance were noted.

Department of Human Services Recommendations:

Based on the review of the information provided by the county in their Act 33 report, it is recommended that counties continue to provide community outreach to local first responders to strengthen knowledge and requirements of reporting. It is recognized that this was a tragic incident and time was of the essence, but with stronger understanding of reporting, county agencies can be involved from the onset, instead of receiving information the next day.