



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Reagan Panick

BORN: [REDACTED]/2010
Date of Death: 08/11/2012

Finalized: 04/08/2013

**The family was not known to Cambria County
Children and Youth Services**

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

1. Family Constellation:

Household Members

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Biological Mother	[REDACTED] 1983
Reagan Panick	Mother's Paramour	[REDACTED] 1987
	Victim Child	[REDACTED] 2010

Non Household Members

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Biological Father	[REDACTED] 1980

Notification of Fatality:

An ambulance was called to the family's home on 08/10/12 shortly before 18:00 for an unconscious person. As the victim child was transported to [REDACTED] she went into cardiac-arrest. The victim child had severe bruising on her head and abdomen as well as injuries to the genitals. [REDACTED] advised that the child's injuries were consistent with [REDACTED] and that the child was in critical condition. The child was life-flighted to [REDACTED]. The report was [REDACTED] for Cambria County Children and Youth Services. The mother's paramour was [REDACTED].

Two hours after the first report a second report regarding the victim child was called into [REDACTED] said that mother knew about bruises to victim child's abdomen and attributed them to falls. The victim child had [REDACTED]. The victim child had a [REDACTED] and continued to be certified in critical condition. The child was on [REDACTED]. This report was [REDACTED] for Cambria County Children and Youth Services. Mother's paramour was [REDACTED] on this report.

On 08/13/12, the Central Region office learned that the child passed away at 8:00 PM on 08/11/12 due to trauma to the head.

2. Documents Reviewed and Individuals Interviewed:

For this review, the Central Region Office of Children, Youth and Families reviewed Cambria County Children and Youth Services (CCC&YS) investigation file which included medical records from both hospitals that treated the child from 08/10/12 until the time of her death.

The Central Region Office of Children, Youth and Families communicated with [REDACTED] [REDACTED] was unresponsive to calls from the Central Region Office of Children, Youth and Families.

Case Chronology:

Previous CY involvement:

Cambria County Children and Youth Services had no involvement with the family prior to receiving the [REDACTED] report on 08/10/12.

Cambria County Children and Youth Services has had two prior intake investigations regarding [REDACTED] (father) when he was a child, but neither report was accepted for services. One was on 01/06/94 and the other was on 06/27/95. It is unknown what these reports were about as these intakes had been expunged by Cambria County Children and Youth Services.

Circumstances of Child's Fatality:

The victim child lived with her mother and her mother's paramour. It was initially reported by the [REDACTED] that the child fell a day prior to the first report to ChildLine and hit her head on a hamper, although she seemed unharmed. On 08/10/12, the mother's paramour was watching the child while the mother was at work. He put the child down for a nap, at which time she appeared to be fine. An hour later, after attempting to arouse the child, she was unresponsive, had no pulse and was not breathing. The mother's paramour called 911. After CPR was performed by paramedics the child had a weak pulse.

The child was transported to [REDACTED] by ambulance, during which time she went into cardiac arrest. Upon arrival to the hospital it was noted that the child had severe bruising on her head and abdomen as well as injuries to the genitals. [REDACTED], advised that the child's injuries were consistent with [REDACTED] and that the child was in critical condition. The child was [REDACTED]. Mother's paramour was the only one home at the time of the incident. The report was [REDACTED] for Cambria County Children and Youth Services with the mother's paramour listed as [REDACTED].

Two hours after the first report a second report regarding the victim child was called into [REDACTED] said that mother knew about bruises to victim child's abdomen and attributed them to falls. The

victim child had [REDACTED]. The victim child had a [REDACTED] and continued to be certified in critical condition. The child was on [REDACTED]. This report was [REDACTED] for Cambria County Children and Youth Services. Mother's paramour was listed as [REDACTED].

On 08/13/12, the Central Region office learned that the child passed away on 08/11/12. The cause of death was listed as blunt force trauma to the head.

Current / most recent status of case:

On 08/11/12, the mother's paramour was arrested by [REDACTED]. The [REDACTED] was charged with criminal homicide, aggravated assault, simple assault, and endangering welfare of children. The [REDACTED] was taken to Cambria County Prison, where he remains. The [REDACTED] waived his right to a preliminary hearing on 11/1/12. There have been no charges brought against the natural mother at this time and it is not anticipated that any will be filed against her.

Cambria County Children and Youth Services [REDACTED] mother's paramour, on 10/2/12. The report was [REDACTED] on 10/2/12 as [REDACTED].

Services to children and families:

There are no other children in the home and the victim child is deceased, as such, there were no services offered to the family. The caseworker inquired as to whether or not the mother was involved in counseling and although she indicated she was not involved, the agency did not provide information about [REDACTED]. Currently, the agency plans to send the mother a letter outlining resources for [REDACTED].

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

A fatality review team meeting was held on September 7, 2012 in conjunction with Act 33 requirements. The Central Region Program Representative participated in the meeting. The County identified compliance with regulations as strength and noted no deficiencies.

County Recommendations for changes at the Local Levels as identified by Fatality Report:

There were no recommendations for change at the local level identified by the Fatality report.

Recommendations for changes at the State Level:

There were no recommendations for change at the state level identified by the Fatality report.

CERO Findings:

The agency should immediately become actively involved with the police when a near fatality or fatality is reported to them. In this situation agency staff did not attempt to join in the police investigation until the weekend after the report was received. At that time the police were already deeply entrenched in the investigation and directed the agency to wait to begin their investigation until the police had interviewed all of the parties involved. The alleged perpetrator declined to be interviewed by the agency although he complied with interviews with the police.

If there is a rotation in on call workers during the course of a weekend, there should be clear communication between the workers about active events that may require intervention from the next shift. In this case, the worker who received the initial call went off duty early the next morning and when the new on call worker was contacted by the hospital, he did not know of the events that had transpired.

The agency should immediately inform both ChildLine and the Regional Office when a near fatality becomes a fatality. The victim child died on 08/11/12 and the Central Region Office was notified of the death on 08/13/12.

Statutory and Regulatory Compliance issues:

There were no statutory or regulatory compliance issues noted.