



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Matthew Baxter

Date of Birth: 10/02/12

Date of Death: 06/11/14

Date of Oral Report: 06/11/14

FAMILY NOT KNOWN TO:

Lancaster County Children and Youth Services Agency

REPORT FINALIZED ON:

03/06/2015

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. Lancaster County Children and Youth Services Agency has not convened a review team in accordance with Act 33 of 2008 related to this report since the investigation was completed prior to thirty days from the date of oral report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Matthew Baxter	Victim Child	10/2/12
██████████	Biological Mother	██████/80
██████████	Biological Father	██████/76
██████████	Sibling	██████/09

Notification of Child (Near) Fatality:

On June 11, 2014, Lancaster County Children and Youth Services Agency received ██████████ due to a death of a child. The medical staff through treatment and analysis found the child to have ██████████ which could determine the child was subject ██████████. The medical staff determined the findings as ██████████ which could have contributed to the child's death. Upon receipt of the initial report the county children and youth agency responded immediately.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records and medical records pertaining to the family. Follow up interviews were conducted with the county agency caseworker ██████████, supervisor ██████████, intake director, ██████████ and agency administrator ██████████ on 6/12/14, 6/13/14, 6/19/14, 7/2/14, and 7/16/14. The Regional Office did not participate in the County Internal Fatality Review Team meeting as the county ██████████ the report prior to the thirty day time period.

Children and Youth Involvement prior to Incident:

The family was not known nor had involvement with the county agency prior to the county's investigation of the aforementioned fatality.

Circumstances of Child Fatality and Related Case Activity:

The family was on vacation from [REDACTED] visiting the Lancaster County area and attractions. On June 10, 2014, the family was spending the evening at the [REDACTED] Inn. The parents were visiting Dutch Wonderland and surrounding area. The victim child's parents reported that the child had a fever of 101 degrees during the afternoon. They administered Tylenol to the child and went back to the hotel for rest. The parents mentioned that the child's fever dropped to a level of around 98 degrees. According to the parents the child was acting normal and went to sleep as usual. In the middle of the night the child woke up screaming, which was reported not uncommon for the child according to the parents. A short period of time later the child awoke again threw his head back and became unconscious. According to the parents the child ceased breathing, the parents called 911. The approximate time of the call was 2:15 am on June 11, 2014. The child's father performed CPR on the child until Emergency Management Services (EMS) arrived on the scene and took over the resuscitation attempts. The child underwent a prolonged period [REDACTED]. The child would have a return of circulation but would lose such again. Continued resuscitation was performed by medical staff. The child was taken to Lancaster General Hospital. The child arrived at the hospital at the time of 2:46 a.m. Medical staff were able to stabilize the child long enough for the child to be transported to Hershey Medical Center.

The child's condition deteriorated at the hospital and a decision was made by the family to take the child [REDACTED]. The hospital staff at Hershey Medical Center did conduct testing prior to the child being taken [REDACTED] checked the child post mortem and found multiple layers [REDACTED]. The hospital initially [REDACTED] An autopsy was scheduled and completed on June 12, 2014. The autopsy did find a milky film on the child's brain. The child's death was caused by a combination of tracheitis, bronchitis, and pneumonia. The autopsy found the death not due or linked to non-accidental trauma. The family has a surviving child, sibling of the victim child. The parents reported this child had a fever earlier in the week but is fine now; the family wanted the sibling further tested head to toe at the hospital to ensure she would not die. Medical staff at the hospital did not feel that was necessary.

The parents were cooperative with law enforcement and the county children and youth's inquiry into circumstances of their child's death. Both parents were interviewed by law enforcement and Lancaster County Children and Youth Services. Due to the specifics of this particular case law enforcement responded both to the hospital and a unit responded to the area hotel [REDACTED] the scene. Nothing suspicious was found at the hotel. The county children and youth services agency assessed the family's surviving child. She was determined to be safe in the care of her parents. Lancaster County Children and Youth Service [REDACTED] on July 3, 2014. The case was [REDACTED] as they could not [REDACTED] to the

victim child. Subsequently law enforcement completed their investigation, the case was closed and no charges were filed. The family returned to their home State of [REDACTED]. Lancaster County Children and Youth Services did complete a referral to [REDACTED] regarding the family.

Current Case Status:

Lancaster County Children and Youth Services completed their [REDACTED] [REDACTED]. The family was not offered services from Lancaster County Children and Youth Services since the family did not reside in either the county or the state of Pennsylvania. However, Lancaster County Children and Youth Services did make a referral to the State of [REDACTED] [REDACTED] for the family.

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

Lancaster County Children and Youth Services Agency did not convene a County Act 33 review as the county agency was not required to do so. The county agency completed their investigation prior to 30 days from the date of oral report. The investigation was [REDACTED].

Department Review of County Internal Report:

N/A

Department of Public Welfare Findings:

The Departmental review of the county's investigation did not find any specific areas of regulatory noncompliance.

Department of Public Welfare Recommendations:

N/A. Due to the circumstances of the particular case.