pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Kacey Wiltrout

Date of Birth: 11/10/2016
Date of Death: 11/26/2016
Date of Report to ChildLine: 11/26/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCIES AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Westmoreland County Children's Bureau
Fayette County Children and Youth Services

REPORT FINALIZED ON:
06/06/2017

Office of Children, Youth, and Families, Western Regional Office
11 Stanwix Street, Room 260 | 412-565-3658 | 412-565-7808 |
www.dhs.state.pa.us

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.

Fayette County has not convened a review team in accordance with the Child Protective Services Law related to this report, as the report of suspected abuse was [redacted] on 12/20/2016.Since the report is unfounded and the investigation was completed within 30 days of the initial report, an Act 33 meeting is not required.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Kasey Wiltrout	Victim Child	11/10/2016
[redacted]	Sibling	[redacted]2014
[redacted]	Mother	[redacted]1994
[redacted]	Father	[redacted]1984
*[redacted]	Maternal Grandmother	[redacted]1968

*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 Western Region Office of Children, Youth, and Families spoke to the supervisor and the county manager of Fayette County Children and Youth Services (FCCYS) regarding the outcome determination being [redacted]. Westmoreland County Children's Bureau (WCCB) and FCCYS provided the file related to this incident and past history.

Children and Youth Involvement prior to Incident:

The mother was involved with WCCB as a teen. The case was originally referred on 01/11/2011 when there was an allegation of physical mistreatment of the mother, who was 16-years-old. The maltreatment allegation was [redacted]; however, there were also parent/child conflict issues, the maternal grandmother is [redacted], and the mother was truant. The case was accepted for services on 03/04/2011. The mother was placed with her maternal aunt and uncle and the case remained open until the mother turned 18-years-old and she left care. The mother also received [redacted] between 12/29/2011 and 09/12/2012.

On 12/02/2014, FCCYS received a [redacted] referral stating that the mother was shooting up [redacted] while she was caring for her oldest child. The reporting source had been advised that the mother was residing with the maternal grandmother in Fayette County. The reporting source saw the mother at the maternal grandmother's home and the mother completed a drug screen which was negative. The mother reported that she was only visiting the maternal grandmother and her residence was in Westmoreland County so the referral information was transferred to WCCB, as it was believed that WCCB was already opened with the family for a [redacted]. However, the referral was screened out by WCCB due to mother testing negative for substances.

On 11/30/2015, WCCB received a [redacted] stating that both parents were using heroin and [redacted]. The mother allegedly had bruising from drug use on her hands, arms and inner thigh and allegedly there were needles on the back of the toilet; there were also drug strips lying around. It was also alleged that the parents would take the child with them when they bought drugs, and that the mother passed out and nodded off while caring for the victim child's sibling. The mother began [redacted] and was prescribed [redacted] in November 2015. On 12/02/2015, an unannounced home visit was conducted and the victim child's sibling appeared to be safe and there were no concerns identified with the home conditions. The mother was tested for drugs on 12/08/2015 and tested positive for [redacted]. The father was tested on 12/17/2015 and tested negative. The parents were referred for [redacted] and the agency made collateral calls with the victim child's sibling's pediatrician. The victim child's sibling had recently attended a well-child check-up and no concerns were noted. A second unannounced home visit was conducted on 12/21/2015 and the victim child's sibling was deemed to be safe. The case was closed on 12/28/2015.

On 11/11/2016, a [redacted] report was made to WCCB related to the mother having another positive [redacted] screen as she gave birth on 11/10/2016 to the victim child. The mother was receiving [redacted] once a month and was involved in [redacted]. WCCB accepted the case for a [redacted] assessment and visited the mother and victim child in the hospital on 11/13/2016. The mother's [redacted] was confirmed as information was obtained through a Release of Information. WCCB attempted an unannounced home visit on 11/17/2016, but no one was home. WCCB received a [redacted] referral on 11/26/2016 related to the victim child's death. The case was referred to Fayette County due to the parents living there at the time. WCCB closed the case on 11/28/2016.

Circumstances of Child Fatality and Related Case Activity:

On 11/26/2016, FCCYS received a [redacted] referral that stated the victim child was brought to Uniontown Hospital and was dead on arrival. The victim child was mottled and possibly malnourished. The parents did not arrive at the hospital for an hour and half. The victim child is deceased as a result of [redacted]. The Fayette County Coroner stated that the victim child possibly was malnourished and

dehydrated so an autopsy was completed. It was also reported that the victim child was born in Westmoreland Hospital; that mother had a history of opiate addiction and reported being prescribed [redacted].

The FCCYS administrator reported that she had met with the family at the hospital, and that she and law enforcement were on their way to the family home. It was confirmed that the parents moved to Fayette County 3-4 days prior to the victim child's death.

The FCCYS Administrator and a Supervisor responded to the hospital and initially met with the social worker and a Trooper from the Pennsylvania State Police (PSP). It was reported that the doctor was concerned because the victim child appeared to be malnourished. The mother was interviewed first. The interview was led by PSP and FCCYS staff observed the interview. The mother reported that she and the father had moved to Fayette County 3-4 days prior and that she has a second child who was 2 years old. The mother provided her demographic information and reported that she and the victim child tested positive for [redacted] at birth. She provided information on the children's pediatrician and signed a Release of Information, and stated that the victim child had not had any follow-up appointments due to transportation issues. The mother stated that she was prescribed [redacted]. The mother also reported that the victim child has resided with her and the father since birth. The mother reported that she arrived home the evening of 11/25/2016 around 9:30 PM after visiting the paternal grandmother's home; that she fed the victim child and went to bed around 11:30 PM. The victim child woke up at 3:00 AM and again at 5:30 AM and she was fed both times. The victim child sleeps in a pack-and-play next to the parent's bed. The mother reported that it was typical for the victim child to wake up two times a night. The mother reported that she woke up at 9:00 AM and the victim child was found to be cold to the touch and not breathing. The father contacted 911 and began cardiopulmonary resuscitation (CPR) on the victim child. The mother identified the maternal grandfather as a caregiver for victim child's sibling.

The father was then interviewed following the same protocol. The father reported that he and the mother along with the victim child went to the paternal grandmother's home to pick up a television stand, arriving home around 9:30-9:45 PM. He stated that he went to bed around 11-11:30 PM. The father and the mother got up around 4:30 AM; the mother fed the baby and the father went outside to smoke. They went back to bed and he was awakened by the mother screaming that the victim child was not breathing. 911 was contacted and the father began CPR on the victim child. The father admitted to using heroin in the past but stated that he stopped using when he found out the mother was pregnant with the victim child's sibling. The father admitted that he used [redacted] that he gets "on the streets" as he does not have insurance. As the administrator was leaving the hospital she was approached by the paternal grandmother who had the victim child's sibling with her.

On 11/26/2017, the FCCYS administrator and supervisor went to the family home. The PSP were there when they arrived. PSP found a bag of needles and the

mother's empty prescription bottle. There should have been pills left per the bottle directions. Two additional prescription bottles were found for [redacted] belonging to the [redacted]. The mother agreed to drug test and was positive for her prescription. The mother admitted that she had not been taking the drugs as prescribed, and that the father was also taking the drugs. The mother denied knowledge of the needles and the father stated they were from when he was using heroin. The father agreed to a drug test and he was positive for marijuana and [redacted]. The maternal grandparents were also present and the maternal grandfather stated that he would care for victim child's sibling during the investigation. The parents agreed and signed a safety plan.

On 11/28/2016, the victim child's sibling had an examination by the pediatrician due to the concern for malnourishment of the victim child. There was no concern noted. Also on 11/28/2016, PSP informed the agency that the [redacted] at the time of death. The victim child's [redacted].

The agency obtained records from 911, Emergency Medical Services (EMS), Westmoreland Hospital, Uniontown Hospital, the children's pediatrician, [redacted] that the mother was attending, and the Coroner's office.

On 12/14/2016, PSP reported to the agency that the toxicology report for the victim child came back with caffeine and no other substance. The caffeine is attributed to the fact that the mother was breast feeding. Per PSP, the Coroner was ruling the death as "Natural." On 12/16/2016, PSP reported that the Coroner stated the victim child was neither dehydrated nor malnourished and that the cause of death appears to be Sudden Infant Death Syndrome (SIDS). The PSP informed the agency that the law enforcement investigation was being closed.

The agency made two home visits to the maternal grandfather's home; 12/06/2016 and 12/21/2016. The mother was also present. The mother tested positive for [redacted]. There was further discussion with the mother regarding the items found in the home.

On 12/22/2016, the agency visited the parents' home and spoke to both parents. The home was furnished with the assistance of family members. Both parents were drug tested. The mother tested positive for [redacted] and the father was negative for all substances. The father reported that he stopped using his pain medication as he does not want there to be any problems related to his care of the victim child's sibling. On this date, the safety plan was revoked and victim child's sibling was to return home later in the day.

The [redacted] investigation assessment summary was submitted [redacted] regarding [redacted]. The initial date of determination by the county was on 12/20/2016. The agency closed the case with the family as it was deemed that the victim child's sibling's needs were being met by the parents, and no safety concerns were identified. The parents have a lot of

family supports to assist them as they grieve the loss of the victim child. A closing letter was sent to the family on 02/02/2017.

Summary of 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 agency did not complete a county fatality report as the [redacted] investigation was deemed to be [redacted] within 30 days of the date of the report.

Deficiencies in compliance with statutes, regulations and services to children and families:

The agency did not complete a county fatality report as the [redacted] investigation was deemed to be [redacted] within 30 days of the date of the report.

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 agency did not complete a county fatality report as the [redacted] investigation was deemed to be [redacted] within 30 days of the date of the report.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

The agency did not complete a county fatality report as the [redacted] investigation was deemed to be [redacted] within 30 days of the date of the report.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

The agency did not complete a county fatality report as the [redacted] investigation was deemed to be [redacted] within 30 days of the date of the report.

Department Review of County Internal Report:

The agency did not complete a county fatality report as the [redacted] investigation was deemed to be [redacted] within 30 days of the date of the report; therefore, there was no report for the Department to review.

Department of Human Services Findings:

County Strengths:

The agency completed a thorough [redacted] investigation, and completed the outcome determination within 30 days of the date of the original report.

County Weaknesses:

No weaknesses identified.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

There are no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

The Department has no recommendations at this time.