



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Isaac R. Rabold

BORN: November 17, 2009
Date of FATALITY: January 17, 2010

**The family was known to Mercer County Children and Youth Services.
The family was known to other public/private social service agencies.**

Report Date: 1/5/2011

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))

Reason for Review:

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 fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

| <u>Name</u> | <u>Relationship</u> | <u>Date of Birth</u> |
|--------------|---------------------|----------------------|
| [REDACTED] | Mother | [REDACTED] 1987 |
| [REDACTED] | Father | [REDACTED] 1986 |
| Isaac Rabold | Victim child | 11/17/2009 |
| [REDACTED] | Brother | [REDACTED] 2007 |
| [REDACTED] | Brother | [REDACTED] 2008 |

Notification of Fatality / Near Fatality:

On January 17, 2010 Mercer County Children and Youth Services received a report from an [REDACTED] stating that Isaac Rabold, age two months, died in his own vomit due to [REDACTED]. The child was in a car seat from 7:00 p.m. on January 16, 2010, until 3:30 a.m. on January 17, 2010. An ambulance was called at 3:30 a.m. due to child suffering from shallow breathing. The child's core temperature was low. The child had sores and dirt in his rolls of flesh and dirt under his fingernails and armpits. Child was pronounced dead at 4:20 a.m. The doctor noted the child was malnourished, cold and pale with sores and dried feces on his body.

Documents Reviewed and Individuals Interviewed:

The Western Region Office of Children, Youth and Family Services (WROCYF) Program Representative reviewed the case file provided by Mercer County Children and Youth Services (CYS) which included: intake referrals made in October and November of 2008, an intake referral received on November 11, 2009, and case file information received subsequent to the report of the child's death on January 17, 2010. The file included the referral, demographic information, parents' statements given to police and other correspondence. Also reviewed were medical records for the child and his two brothers. Face to face interviews were also conducted with the caseworker, the supervisor and the director of the agency.

Previous CY involvement:

There were two previous referrals made to Mercer CY on the family. The first report was made by [REDACTED] on 07/25/ 2007. [REDACTED] reported that the mother was not aware of her pregnancy up until the time of her child's birth and this raised serious concerns about her ability to parent. The mother of the child was living with her parents and had sufficient supports in place that were able to help her with the care of her child. The referral was closed upon completion of the intake assessments. The mother was also given information on the [REDACTED]. She was also a [REDACTED] and had to go to periodic appointments with the children. No reports were made by [REDACTED] as a result of her visits.

A second referral on the family was received from [REDACTED] on 11/13/08 to Mercer CY due to [REDACTED] having a bruise on his face. It was reported that his brother [REDACTED] accidentally head butted the child while playing with the child. This was a [REDACTED] and was closed on 11-18-08.

According to Mercer County's record, there were no other reports related specifically to the [REDACTED] family until the death of Isaac Rabold on January 17, 2010. However it must be noted that there is conflicting information as to whether or not additional referrals had been received.

On Wednesday November 11, 2009 (which would have been eight days prior to the birth of the victim child) about 3:30 p.m. the [REDACTED] Police Department were dispatched to [REDACTED] for the front door being open and dogs running loose in the area. According to law enforcement, the home was found to be in deplorable condition. Upon the police entering the house with the landlord, they determined that it appeared there were small children living in the home due to dirty diapers throughout the house, urine and feces within a baby crib. There was also smeared feces on the walls where the crib was found which appeared to be done by children's fingers. The home was in disarray with clothes and trash throughout the house and dog feces on the floor. The tenants could not be found on the premises. There was nobody in the house at that point but it did appear that people were living in the house since there was food in the refrigerator and utilities were on.

According to the police report, while police were there a gentleman by the name of [REDACTED] came to the home. The [REDACTED] informed him that CY would be coming out the next day and that he and his girlfriend [REDACTED] needed to clean up the house. In the report it says that [REDACTED] told the [REDACTED] that his 1year old sleeps in the crib where the feces were found. [REDACTED] then referred the situation to Mercer County CY.

Later that evening [REDACTED] stated that they spoke with the father [REDACTED] and informed him that the house was unlivable and that they needed

to clean the place up if they were planning to live in the home with their children. The [REDACTED] did not see any children and states that he called Mercer CYC and informed them that the father was there and that they should contact him. The [REDACTED] stated that CYC responded that they would go to the home the next day and do an assessment.

Mercer County CYC states that when this report was received by the intake worker that the [REDACTED] gave them the name of [REDACTED] as the resident of the home. The [REDACTED] are however stating that the name that was given was [REDACTED]. The documentation that was found in CYC records identifies [REDACTED] as the individual residing in the home. This was a serious communication problem between the Agency and the [REDACTED] Police Department.

Mercer County CYC caseworker [REDACTED] states that the name she was given as the subject of the complaint was [REDACTED]. The next day CYC went to home looking for a [REDACTED]. Case record shows attempts were made to contact the family through unannounced home visits on 11-12-09 at 3:47 PM, 11-20-09 at 1:00 PM, 12-15-09 at 2:30 PM, 12-17-09 at 11:30 AM, 12-21-09 at 2:00 PM and 1-6-10 at 1:00 PM. CYC was unable to gain access to the home. It should be noted that there were no attempts made to visit the home at night. In addition to the attempted visits to the home, a letter was written to [REDACTED] at that address requesting contact with the agency and three phone calls were made with messages left for [REDACTED] to contact the agency.

There was no follow up between Mercer CYC and the [REDACTED] Police Department. CYC failed to follow up with the police, the landlord or any of the neighbors. Toward the 60 day deadline to complete intake assessments CYC closed the case on 1-9-10. The decision to close was based on the agency's determination that [REDACTED], who they believed [REDACTED] had referred for service, did not have any small children and that all her children were grown. This determination was based solely on information contained in the [REDACTED] report that the agency had failed to verify. The intake was officially closed on January 9, 2010.

On January 17, 2010, Mercer County Children and Youth Services received a referral stating that Isaac Rabold had died on 01/17/10, as the child was found having problems breathing due to being left outside in the frigid cold for 30-60 minutes. The incident had occurred at [REDACTED] address, which corresponded with the address provided in the November 11, 2009 report the police had made.

Circumstances of Child's Fatality:

During the early hours of January 17, 2010, the father, [REDACTED], called his mother because the baby was very warm. His mother informed [REDACTED] to take the child outside for a couple of minutes to try and cool baby off. The father reported to [REDACTED] Police that he took the child out on the porch and left child outside for about 30 minutes. The mother stated that child was left outside for an hour or more. She stated that they forgot he was outside. When they brought the baby back inside they noticed that his breathing was shallow and called 911 and then the baby was taken to UPMC Horizon in Greenville.

The child victim died on January 17, 2010. An autopsy was completed by [REDACTED] Forensic Pathologist who concluded the cause of death was homicide; due to [REDACTED]

[REDACTED] The child was found to be profoundly undernourished and emaciated with evidence of dehydration. There was evidence of a [REDACTED]

Both parents have been charged with homicide in the death of their child [REDACTED]. Both parents were given [REDACTED] evaluations and it was recommended that their [REDACTED]. The parents remain incarcerated awaiting trial.

The surviving siblings were placed in foster care with a contracted provider immediately following Isaac's death. The children are placed in the same foster home with foster parents who are willing to adopt. At the time of their placement, they were medically assessed; both were identified with significant developmental delays. Since placement both have made significant gains and are thriving in their current environment. At the time of their placement, relatives had expressed interest in being caretakers for the children; however, an evaluation of their capacity to care was determined to be unsatisfactory.

County Strengths and Deficiencies as identified by the County's Internal Review:

Strengths

At the county child fatality team review held on 7-23-10, Mercer CYS reported it had complied with statutory and regulatory requirements related to its investigation of the abuse report related to Isaac's death. Mercer CYS has developed a protocol for following up with referral sources in hopes of preventing any future miscommunication mishaps. Mercer CYS will also conduct CPSL trainings every 3 months for the next year to educate medical professionals on the roles and responsibilities of mandated reporters based on concerns that a pediatrician had expressed prior to the fatality team meeting.

Deficiencies

It was acknowledged by Mercer CYS that the agency failed to follow up with the Police Department, the landlord of the property or any neighbors. There were also serious miscommunication issues between the agency and the Police Department. The [REDACTED] reports have the wrong names in the [REDACTED]

However, if CYS would have gotten back in contact with the police, [REDACTED] they may have gotten more information on who actually lived in the home.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Fatality Report:

The county did include recommendations for changes in the report submitted. Mercer CYS has agreed to conduct CPSL trainings every 3 months over the next year which will be provided for all medical professionals so that they are aware of all CPSL mandates. They will also develop a protocol for following-up with reporting sources.

Western Region Findings:

Staff of the Western Region Office of Children Youth and Families have, after reviewing the case record and interviewing the casework manager, supervisor, and Director of Mercer CYF, identified significant areas of concern regarding Mercer CYS's response to the [REDACTED] involving the [REDACTED] family received on November 11, 2009. The concerns are as follows:

- There were serious communication problems between Mercer County CYS and the Greenville Police Department. The caseworker should have

contacted the reporting source immediately since they were unable to contact a family who was living at the property.

- The landlord of the property was never contacted to see who exactly was living in the home. If this had been done CY5 could have identified the residents of the home.
- The children were never seen and the case was closed without completing risk or safety assessments even though there was ample evidence that a family with young children was living in that home.
- Mercer CY5 failed to conduct a diligent search for the family that lived in the residence.
- Mercer CY5 did conduct proper investigations on the [REDACTED] referrals which were conducted on 10-14-08 and 11-13-08.

Statutory and Regulatory Compliance issues:

The agency failed to provide [REDACTED] services to 3 children under the age of 2 to prevent [REDACTED] of the children. The agency failed to see the children and did not assure safety of the children, visit the home, interview the reporting source, or provide services to a family in need of [REDACTED] services. The agency never notified the parents of the receipt of the report. The supervisor log failed to assess the case to assure that the level of service was consistent with the level of risk and failed to determine safety. The agency failed to properly assess the characteristics of the family, evaluate the environment in which the family resided, complete a risk assessment on the family, or include the previous history of [REDACTED] before making a determination to close the [REDACTED] family for services on 1-9-10.

The agency will be required to submit a corrective action plan to address the areas of non-compliance identified through this review.