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REPORT ON THE FATALITY OF:

NATALEE MIBRODA

Date of Birth: 12/07/2011
Date of Death: 12/27/2011

FAMILY WAS NOT KNOWN TO WESTMORELAND COUNTY CHILDREN'S BUREAU

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 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.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Mibroda, Natalee	Victim Child	12/07/2011
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Father	[REDACTED] 1986

Notification of Child Fatality

On December 29, 2011, it was reported to the Westmoreland County Children's Bureau that the child, Natalee Mibroda, had died on December 27, 2011. The child had been transported by ambulance to [REDACTED], [REDACTED] PA. The child was pronounced dead at 2:10pm on December 27, 2011. [REDACTED]

The injuries to the child occurred while the father was the sole caretaker of the child, as the mother was confirmed to have been at a doctor's appointment for herself.

Summary of DPW Child (Near) Fatality Review Activities

The Western Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. The Westmoreland County Children's Bureau granted the Western Regional Office access to CAPS, their electronic case management system, in order to provide the Regional Office with the most up-to-date information related to the case. This access was provided immediately upon the registration of the fatality with [REDACTED]. Also, the Regional Office reviewed documents from Indiana County Children and Youth Services, as they completed an assessment of the children after the child was discharged from the hospital. The parents were residing with the paternal grandmother after the birth of the child, as she was assisting the parents in establishing a routine for the victim child and her young sibling. It should be

noted that the parents and the parental grandparents live in very close proximity, however the parents resided in Westmoreland County, and the paternal and maternal families reside just over the border, in Indiana County.

Additionally, interviews were conducted with the County caseworker, supervisor and County Case Manager. The Regional Office also participated in the County Internal Fatality Review Team meeting that occurred on February 22, 2012.

Summary of Services to Family

At the time of the child fatality, the family was under assessment by the Westmoreland County Children's Bureau for a [REDACTED] referral received on December 8, 2011. No other services were being provided to the family.

Children and Youth Involvement prior to Incident

Westmoreland County Children's Bureau had only one incident of prior involvement with this family prior to the child's fatality on December 27, 2011. The County received a [REDACTED] referral, reported by the [REDACTED]. The report was received on December 8, 2011, stating that the mother had given birth to the victim child on December 7, 2011, and both the mother and the baby tested positive for [REDACTED]. The mother reported that she did not have a prescription for any [REDACTED]. She further reported that she had back pain, and the doctor told her to take an over-the-counter pain reliever, however she did not believe that would work for the severe pain she was allegedly suffering.

At the time of the referral, the victim child was not showing any signs of withdrawal, but the pediatrician advised that it may take awhile for any symptoms to appear. The [REDACTED] had already made arrangements for a [REDACTED] to enter the home to monitor the child. It was also reported that the mother and victim child would be [REDACTED] the following day, December 9, 2011.

As initially reported by the referral source, the mother and victim child were [REDACTED] on December 9, 2011 with a [REDACTED].

The victim child and parents chose to stay in Indiana County after the child's birth, with the paternal grandmother, for assistance in establishing a routine for the child. When this was learned, the Westmoreland County Children's Bureau caseworker contacted Indiana County Children and Youth Services intake to request a courtesy safety assessment. It was learned through phone contact with the parents that they would be with the paternal grandmother for approximately one week.

The Indiana County Children and Youth Services intake worker made contact with the parents and the paternal grandmother on the date of the referral from Westmoreland County Children's Bureau, December 12, 2011. The Indiana County caseworker reported to the Westmoreland County that a safety assessment and courtesy interview occurred at the home of the paternal grandmother. During the interview, the paternal grandmother expressed concerns for the victim child's sibling, [REDACTED], as he had been diagnosed with [REDACTED]. The paternal grandmother reported that the parents never brought the child's [REDACTED] to her home; however the paternal grandmother had a [REDACTED] for this child to use. She also expressed concerns about the parents living arrangements, as they resided in Westmoreland County, in what the paternal grandmother described as marginal housing. The Indiana County caseworker also reported a past referral to their agency after an altercation between the parents. This [REDACTED] report was assessed and [REDACTED] as the child was not in danger. It was also reported that the parents had planned on returning to their home on this date. Indiana County forwarded all documentation to Westmoreland County.

On December 12, 2011, the Westmoreland County Caseworker made an unannounced home visit to the parents' home. The parents were unaware that the caseworker was arriving at the home, and originally believed the caseworker was the [REDACTED] who forgot her [REDACTED]. After identifying herself, the father let the caseworker into the home. It was soon learned that the victim child was not home, and was in fact still with the paternal grandmother. This was a private arrangement established by the parents and the paternal grandmother that was in effect for the victim child and the sibling. The caseworker was able to assess the home of the parents, and the safety of the victim child's sibling, [REDACTED]. Natalee remained with the PGM who was assisting parents to get child on a schedule. The parents verified that they had one past referral to Indiana County Children and Youth Services, reporting that they were involved in an argument resulting in the State Police arriving, and contacted Indiana County Children and Youth Services. The parents both stated that Indiana County Children and Youth Services came to their previous residence, then closed the case.

The caseworker then spoke separately to the mother, who reported she tested positive for [REDACTED] at the victim child's birth because she took a [REDACTED]. She reported that she did not have a prescription, and that she took the pill from an aunt. The mother reported she was in pain due to having [REDACTED] and had trouble lifting the victim child's sibling while being pregnant. The mother reported that she was not taking anything for pain, and that she was using a topical cream that the doctor had given her, that seemed to be helping.

The caseworker presented the parents with possible services for parenting, support, and education due to having children so close in age. The parents reported that they do not wish to have services at this time. The caseworker reported no observation of any visible signs [REDACTED] with [REDACTED].

Additionally, the caseworker walked through the parent's house and observed the children's room. The victim child's sibling had a pack and play. The parents reported that they had a crib for the victim child, but had not put it up yet as the home was the maternal grandmother's, and she was in the process of moving out to allow the parents and children to live there. The caseworker encouraged the parents to put the victim child's crib up in anticipation of the child coming home from the paternal grandmother. The parents also had a bassinet in the living room area for the victim child. The caseworker observed formula and appropriate food in the house for both children. The parents reiterated that they were having the victim child stay with the paternal grandmother for about a week or two to get help establish a schedule, due to having two infants close to same age. The parents again reported that they did not wish to have services.

On 12-13-11, Indiana County was contacted and CW [REDACTED] went out to PGM home and conducted a safety assessment with victim child Natalee and PGM [REDACTED]. Natalee was returned home on 12-21-2011.

Circumstances of Child Fatality and Related Case Activity

On December 27, 2011, the Westmoreland County Children's Bureau was notified by the Indiana County Crimes Unit of the Pennsylvania State Police that a child had passed away at 2:10pm. At the time of this report, the child's cause of death had not been determined. On December 28, 2011, the County caseworker contacted the investigating State Trooper, who reported that the child had been transported to the emergency room via ambulance, and presented with bruising to the neck, shoulder, head and had bleeding from the mouth. At this point, it was still unclear as to how the child died.

The investigating State Trooper did note that the parents presented with conflicting stories. The father reports that he got up at 5:00am to feed the child on December 27, 2011, and that everything was okay. From the interviews, the State Trooper identified that the mother awoke later in the morning, and left for a doctor's appointment without checking on the child. The mother arrived home around lunchtime after getting a prescription filled following her appointment. The mother went to check on the child, and was told by the father that since she was on new medication, that she should not care for the child. The mother then left the home, and went to the home of the maternal great-grandmother, who lived in Indiana County.

At approximately 1:30pm, the maternal great-grandmother and the mother arrived back at the parents' home and demanded to see the child. The father would not allow this, so the maternal great-grandmother called 911 emergency services from the home of a neighbor. While this call was made, the father exited the home with the child wrapped in a blanket, locked himself and the child in the front seat of a car, and waited for the ambulance.

At this point, the victim child's sibling was in the care of the paternal grandmother at the request of the PA State Police who arrived on scene. Westmoreland County Children's Bureau also developed a safety plan, signed by all parties, that the surviving child would remain in the care and custody of the paternal grandmother pending the outcome of the investigation.

On December 28, 2011, an autopsy was performed in Allegheny County. The Indiana County Coroner has requested assistance from Allegheny County in determining the cause of death to the victim child. The Coroner established the cause of death as homicide. The pathologist who assisted in the autopsy, [REDACTED] from Allegheny County reported that the child suffered several serious inflicted injuries, which included [REDACTED]

[REDACTED] Established timelines consistent with the injuries place the father as the sole caretaker for the child at the time the injuries were inflicted. The father was arrested and detained in the Westmoreland County Jail awaiting formal arraignment.

As the surviving child was in the custody of the paternal grandmother in Indiana County, the Westmoreland County Children's Bureau caseworker contacted Indiana County Children and Youth Services to notify them that the child was residing in their County, and that this was an established safety plan signed by all parties. Indiana County then had a caseworker again assess the safety of the surviving child on December 29, 2011, and establish a safety plan the mirrored that developed with the family and Westmoreland County.

On December 30, 2011, the mother contacted the Westmoreland County Children's Bureau caseworker and stated that she wanted the surviving child returned to her care and custody. The County agency consulted with the County District Attorney, who stated that their office was requiring a skeletal survey of the surviving child because of concerns that the mother may have known about the incident that happened to the victim child.

The skeletal survey occurred on December 30, 2011. The results were returned to the Westmoreland County Children's Bureau on January 4, 2012, which showed normal findings for the surviving child.

On this same date, the mother reported that she understood that the surviving child could not yet be returned to her custody, but she was not happy with the paternal grandmother caring for the child anymore and wanted the surviving child placed with a cousin. The Westmoreland County Children's Bureau obtained the cousin's information from the mother, and began to complete preliminary background checks to see if the kinship placement would be suitable.

On January 6, 2012, the paternal grandmother contacted the Westmoreland County Children's Bureau and informed the caseworker that she and the step-paternal grandfather

[REDACTED]

The Westmoreland County Children's Bureau determined the status of the [REDACTED] investigation to be [REDACTED] on February 23, 2012, naming the father as the [REDACTED]. As no family members resided in Westmoreland County any longer, a formal referral was made to Indiana County Children and Youth Services. A copy of the entire case file was mailed to Indiana County on February 27, 2012.

The father continues to be housed in the Westmoreland County Jail. He had a preliminary hearing on February 24, 2012, and is awaiting trial on the charges of criminal homicide.

Current Case Status

There are no family members residing in Westmoreland County at this time. At the time of the status determination, a referral was made to Indiana County Children and Youth Services, who did not open the case, as the surviving child was safe [REDACTED] of the paternal grandmother and the step-paternal grandfather.

The father is awaiting trial in the Westmoreland County Jail.

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

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. Westmoreland County has convened a review team, however it was not held in accordance with Act 33 of 2008 related to this report. The County held the internal child fatality meeting after [REDACTED] the report, but did not convene the meeting within 30 days of the referral from [REDACTED] with the status determination not being made.

- Strengths
There were no strengths identified by the County.
- Deficiencies:
There were no deficiencies identified by the County.

- Recommendations for Change at the Local Level:
There were no recommendations for change at the local level identified by the County.
- Recommendations for Change at the State Level:
There were no recommendations for change at the State level identified by the County.

Department Review of County Internal Report

The Department was in receipt of the County Internal Report. While it did not identify any strengths or deficiencies, there were several strengths noted by the Department in this case. This feedback was provided to the County verbally on February 22, 2012.

Department of Public Welfare Findings:

- County Strengths:
There were several strengths identified in the review of this child fatality. The County was diligent in their investigation, and worked collaboratively with law enforcement, medical professionals and a neighboring County children and youth agency. The case documentation completed by the County caseworker was exceptional, being very detailed and well organized. Safety and risk assessments were completed at the correct intervals, and the established safety plans for the surviving child were thorough, detailed, and tailored to suit the safety and well-being of the child.
- County Weaknesses:
The Department did not identify any weaknesses in the review of this case.
- Statutory and Regulatory Areas of Non-Compliance:
The County did not hold their internal Child Fatality Review Team meeting within 30 days of the report to [REDACTED] when the status determination was not made. The County did convene the review team meeting after the status determination was made to be [REDACTED] however this was after the 30 day timeframe. The Regional Office conducted technical assistance with the County on February 22, 2012 related to this requirement.

Department of Public Welfare Recommendations:

The Department recommends better collaboration with hospitals at the time of the referral, to establish accurate discharge dates for the children, as well as

collaboration with the home health professionals to allow for transparent communication regarding the safety of the children they serve.