



Edward Coleman
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-4376
Fax (570) 963-3453

OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503

REPORT ON THE FATALITY OF

Raven Breunig

Date of BIRTH: August 27, 2009

Date of FATALITY: March 13.2010

Report Date: August 12, 2010

Family was not known to Berks County Children and Youth

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 by Governor Rendell on July 3, 2008 and went into effect on 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 reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Circumstances of Fatality/Near Fatality:

Raven Breunig, age six months, of [REDACTED] Topton, Pa. 19562 was found deceased by her parents on Saturday March 13, 2010 at 7:46 PM. [REDACTED] was notified of the death at [REDACTED] born one month premature. The child was found to be unresponsive. The child had died before the EMS team arrived. There were no other children in the home. Law enforcement was notified and a search warrant was requested. The case was [REDACTED] due to the circumstances of her death, bruising to left thigh, a scrape under one eye and severe diaper rash. [REDACTED] The family did not have a history with Berks County Children and Youth Services. [REDACTED]

Family Constellation:

Name:	Relationship:	Date Of Birth:
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Father	[REDACTED] 1981
Raven Breunig	Deceased Child	08/27/2009

Documents Reviewed and Individuals Interviewed:

The entire intake file was reviewed, including all reports made and received by Berks County Children and Youth Services (CYS), [REDACTED] Reports, Safety Assessments, Contacts and Risk Assessments. The county caseworker, supervisor and administrator for Intake Services were interviewed.

Case Chronology:

3/13/2010 Berks County Children and Youth Services received a report [REDACTED] regarding the death of a child approximately 6 months of age. The child was deceased by the time EMS arrived. [REDACTED]

3/13/2010 Berks county caseworker contacted [REDACTED] [REDACTED] to obtain some more details on the case. No other children are in the home. Parents report last seeing the child alive at 5:30 PM on 3/13/2010, conscious and doing well. [REDACTED]

3/14/2010 [REDACTED] Berks Co CYS attended the autopsy. Only minor bruising on the child was noted and no other marks. [REDACTED] were consistent with their story stating they had fed the child around 5 or 5:30 pm and she went to bed. It appears to be a [REDACTED] but death results are pending because there is more testing to be conducted.

3/14/2010 Telephone contact with [REDACTED] [REDACTED] Child could have been in the crib all day and they were caring for basic needs only. Child had a severe rash [REDACTED]. They reported that they did visit with the family and knew that the baby had just had a doctor's appointment [REDACTED] Caseworker attended the autopsy. [REDACTED]

3/15/2010 Caseworker met with [REDACTED] at the home and discussed the [REDACTED] [REDACTED] was not home at the time of interview. According to the [REDACTED] the child [REDACTED], according to [REDACTED] Caseworker asked if the child was receiving treatment for [REDACTED] [REDACTED] stated the child was receiving treatment and showed caseworker a tube of medication dated 3/1/10. The child was seen [REDACTED]

3/17/2010 [REDACTED] called the caseworker to inquire about case. Arrangements made for the mother to be interviewed on 3/22/2010.

3/22/2010 The mother came to [REDACTED] [REDACTED] told the caseworker that on 3/19/10 she had a headache all day and was in bed. She stated [REDACTED] The baby was quiet so they checked on

her and realized something was wrong. The parents called 911. The mother was asked about diaper rash cream and claimed to have used it 3 or 4 times a day. Caseworker confronted her about the unused tube and she had no response. Then the caseworker asked about the unsanitary conditions of the home. The mother replied that she was not feeling well. [REDACTED]

3/24/2010 Caseworker waiting results of autopsy [REDACTED]

4/17/2010 Caseworker waiting results of autopsy.

4/27/2010 [REDACTED]

Death is

[REDACTED] No other children.

[REDACTED] Letters sent to [REDACTED]

Statutory and Regulatory Compliance by the County Agency:

The agency has met all statutory requirements. Agency is in full regulatory compliance. The risk assessment was completed. The safety assessments were accurate and completed. Law enforcement was notified through the submission of [REDACTED], however, [REDACTED] the agency as [REDACTED]. This child was receiving no other services and had been to the doctor for [REDACTED]. The family, at the time of death, was not receiving any services from Berks County Children and Youth Services [REDACTED]

All persons involved in case were interviewed including intake manager, casework supervisor and caseworker. Record received and reviewed.

Case was presented at MDT. No internal review was held.

Findings and Recommendations:

At the time this report was generated, the Agency was in need of an Internal Review Team. The administrator of the Intake department had been attempting to develop the team but had not received final commitments from potential members. The agency is fully aware that the review process is required. The team is now developed and has met on three occasions. They are a very active team and involved in the process of discussion with adequate diverse representation.