pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

David Berger, Jr.

Date of Birth: 12/20/2012
Date of Death: 6/27/2013
Date of Oral Report: 6/27/2013

FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD WELFARE AGENCY

REPORT FINALIZED ON:
12/29/2013

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))

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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. Bucks County convened a review team in accordance with Act 33 of 2008 related to this report on 7/23/2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
David Berger, Jr.	Victim child	12/20/2012
[redacted]	Mother	[redacted]/1989
	Father	[redacted]/1990

Notification of Child Fatality:
On 6/27/2013, Bucks County Children and Youth Social Services Agency (BCCYSSA) received a report concerning the near fatality of David Berger, Jr., age 6 months old. The child had been in the care of his father while the mother was at work on 6/26/2013. The mother returned home from work at 3 pm to find David unresponsive. He was first taken by ambulance to St. Mary's Hospital, then transported to Children's Hospital of Philadelphia (CHOP) and [redacted]. CHOP determined that David had [redacted] and [redacted]. There was no history given by the parents how this could have occurred. The [redacted] was listed as alleged perpetrator as [redacted] was caretaker at the time of the injuries. The child was not expected to survive.
David died 6/27/2013 at CHOP. Injuries were identified as non-accidental traumatic injury caused by blunt force trauma.

Summary of DPW Child Fatality Review Activities:
The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to this family. The SERO participated in the county's Act 33 Review on 7/23/2013. Present during this review were the [redacted] police detective, county detectives, and the Philadelphia Medical Examiner's investigator.

Children and Youth Involvement prior to Incident:
This family had no prior county involvement, either as children or parents.

Circumstances of Child Fatality and Related Case Activity:

David was found unresponsive in his home by his mother about 3 pm. He was transported to St. Mary's Hospital and [redacted]. He was later transported to CHOP. He was found to have [redacted]. CHOP determined that this was [redacted]. The parents could not provide any history how this could have occurred.
The baby was pronounced dead on 6/27/2013.
David had no known medical problems; he had been recently seen at his primary care physician. The mother was reported [redacted]; the father reportedly [redacted] The [redacted] detective took blood from the father for drug testing. The [redacted] detective and county detectives made contact with the Medical Examiner's Office. On 7/1/2013, the assigned Medical Examiner (ME) reported that the cause of death was not homicide as there was not any sign of [redacted]. The ME further reported that the [redacted] seen by CHOP could have been the result of the extensive resuscitation efforts.

Current Case Status:
This case was [redacted] based on the medical evidence. No criminal charges are pending. The parents had no other children, so no services are heing provided. The parents were referred for [redacted].

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

- Strengths:
- None identified

- Deficiencies:
- None identified

- Recommendations for Change at the Local Level:
- Additional education concerning co-sleeping
- Continued collaboration amongst law enforcement, medical staff, and children and youth agencies

- Recommendations for Change at the State Level:
- Additional education concerning co-sleeping
- Continued collaboration amongst law enforcement, medical staff, and children and youth agencies

Department Review of County Internal Report:

The Regional Office received the county report on 9/10/2013. The county agency had no prior knowledge of this family. This case demonstrated excellent collaboration between the police, county detectives and Medical Examiners' Office.

Department of Public Welfare Findings:

- County Strengths:
- County collaborated with the hospital and law enforcement during this investigation. The Medical Examiner's Office communicated in a timely manner with law enforcement and the county children and youth agency.

- County Weaknesses:
  None identified

- Statutory and Regulatory Areas of Non-Compliance:
  None identified.

Department of Public Welfare Recommendations:

During the initial investigation, the county detectives took the time to gather medical information from CHOP and the ME's office prior to interviewing the parents. This thoroughness impacted how their interviews with the father were conducted. Rather than approaching the father aggressively [redacted], the detectives approached him as a parent who had lost his child for no explainable reason. The detectives proceeded very sensitively with the parents, and even suggested that they follow up with some [redacted]. This type of investigation effort should be commended.