



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Kestyn Davis

Date of Birth: 10/15/13
Date of Incident: 12/24/13
Date of Oral Report: 1/7/14

FAMILY NOT KNOWN TO:

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:

October 3, 2014

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))

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. On February 5, 2014, Lancaster County convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Kestyn Davis	victim child	10/15/13
██████████	mother	██████/87
██████████	father	██████/78

Notification of Child Fatality:

On December 24, 2014, the victim child, a two month old baby, received a single gunshot wound to her abdomen while sleeping in the home. The child and ██████████ were the only persons in the home at the time of the incident. The child was resting in a glider swing in the living room area. ██████████ and law enforcement arrived at the scene. According to the victim child's ██████████, the gun accidentally fired while ██████████ was in ██████████ words "messaging" with the fire arm. The gun was a recent purchase for the victim child's ██████████ and, according to law enforcement, was a highly advanced classification of firearm. The victim child was taken to Lancaster General Hospital. The child was pronounced dead at the hospital a short time after ██████████. The date of death is the same date as the incident. Due to the caliber of weapon and the age of the child, ██████████ was unsuccessful at being able to save the child due to extensive trauma which occurred. Lancaster County Children and Youth Services received a ██████████ report ██████████ regarding this incident on January 7, 2014.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to this family. Follow up interviews were conducted with the county agency caseworker ██████████, supervisor ██████████, intake director, ██████████ and agency administrator ██████████ on January 7th and 9th, February 7th and March 6th, 2014. The Regional Office participated in the County Internal Fatality Review Team meeting on February 5, 2014.

Children and Youth Involvement prior to Incident:

Lancaster County Children and Youth Agency did not have any prior involvement with the family.

Circumstances of Child Fatality and Related Case Activity:

On the afternoon of December 24, 2013, the child's [REDACTED] was alone in the home with the victim child. The child's [REDACTED] was not present in the home at the time of the incident. The child was asleep in the living room of the apartment resting in an age appropriate glider swing. According to the information reported, the [REDACTED] went upstairs to take a shower. Prior to [REDACTED] return downstairs, [REDACTED] brought a recently purchased handgun downstairs. [REDACTED] intent was to handle the gun and later show the gun to a relative who would be visiting due to the upcoming holiday. The [REDACTED] informed law enforcement that [REDACTED] was "messing" with the fire arm in the living room. [REDACTED] was handling the weapon pulling the slide back and forth, and taking the gun's magazine clip in and out of the weapon. It was reported the gun was loaded with 10 rounds. The weapon, a Springfield 9 millimeter, can be consider an advanced weapon in the firearms industry and is not necessarily considered a model intended for use with novice handlers. The [REDACTED] was inexperienced in use of handguns and this was his first handgun purchase. The [REDACTED] placed the weapon on the coffee table and entered the kitchen.

The [REDACTED] returned to the room and sat on the couch. While seated, [REDACTED] grabbed the firearm in one motion and pulled the trigger. The [REDACTED] intended to pull the trigger; however, [REDACTED] did not believe there was a bullet in the chamber. Thus [REDACTED] did not believe by pulling the trigger that the weapon would fire. As reference, the act was one motion. The firearm was not aimed when the weapon fired. According to the report, the child's [REDACTED] did not initially realize where the bullet's path went nor did [REDACTED] see where the bullet came to rest. Tragically, the bullet struck the child in her abdomen and, due to her body positioning and size of the bullet, caused severe trauma to the child. The [REDACTED] immediately called for [REDACTED] and law enforcement got to the home within minutes. However, due to the injury received, [REDACTED] was not able to save the young child. The child was taken to [REDACTED]. The child expired at the hospital on the same date as the incident.

An autopsy was conducted on December 26, 2013. The cause of death was ruled one single gunshot wound to the child's abdomen. Law enforcement completed their investigation. The [REDACTED] was charged and plead guilty to involuntary manslaughter as well as misdemeanor counts of endangering a child and reckless endangerment. It should be referenced, that drugs and or alcohol did not play a role in this incident nor did [REDACTED] have any reported [REDACTED] issues. The victim child's [REDACTED] and family are devastated by the events which have transpired. Lancaster County Children and Youth Services completed their [REDACTED] on March 5, 2014. The [REDACTED] did not speak to the agency as advised by legal counsel. Due to the circumstance of the case, the agency [REDACTED] the [REDACTED] under the child protective services law.

Current Case Status:

Lancaster County Children and Youth Service Agency did not open the family for services. The victim child was the [REDACTED] child. The [REDACTED] was charged by the Lancaster County District Attorney's Office. A formal sentencing date will be scheduled.

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

Strengths:

The county report referenced that the county agency conducted the investigation in a timely manner and had collaboration with law enforcement.

Deficiencies:

The report referenced better understanding of fire arm safety. The [REDACTED] could have benefited from more gun education and training for the specific purchased model. The gun should not have been loaded and the safety lock should have been on the gun. The report referenced that the owner of the firearm should have had more familiarization of the weapon and not have been handling it in the presence of the child.

Recommendations for Change at the Local Level / State Level:

The recommendation for change for this particular report can cross over both the local level and the State level. However, the report did not specify or further break out the recommendations. The major discussion was in the area of gun awareness and safe handling.

The report referenced possible recommendation to advocate for training when purchasing a firearm; explore application for a gun permit and requirements if weapon training and safety course is required prior to the purchase of a firearm; information packets should be provided to gun owners at time of purchase regarding awareness of children and potential dangers. In addition, hospitals may further provide information packets (or pamphlets) to new parents at the hospital regarding gun safety and the potential danger of firearms around children.

Department Review of County Internal Report:

The Department reviewed the Act 33 county fatality report submitted on February 7, 2014 by Lancaster County Children and Youth regarding this case. Due to the circumstances of this particular case, the regional office concurs with the report.

Department of Public Welfare Findings:

County Strengths:

The county children and youth agency responded immediately once the report was received. Both law enforcement and the county agency had good collaboration conducting the investigation. The county agency was able to request and obtain prior medical history and care sought for the victim child.

County Weaknesses:

The review of the case materials associated with this particular case did not substantiate any major weaknesses associated with the county children and youth agency.

Statutory and Regulatory Areas of Non-Compliance:

The review of the county case file notes and other pertinent records did not find any areas of noncompliance.

Department of Public Welfare Recommendations:

It is recommended that the county explore if additional community outreach, as referenced in their report, may be of value. The County Sheriff's Office already provides classes on firearm safety to the public. Further collaboration between agencies regarding this subject could bolster attendance and overall awareness.