



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Peyton Regan

BORN: December 21, 2007
DIED: July 1, 2011

The family was known to Allegheny County Children and Youth Services.

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 [REDACTED]. 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. Allegheny County has 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>
Peyton Regan [REDACTED]	Child [REDACTED]	12/21/2007 [REDACTED]

Notification of Child Fatality

The Allegheny County Office of Children Youth and Families received a referral through the [REDACTED] Police Department regarding the death of Peyton Regan which occurred on July 1, 2011. It was reported that the child accidentally shot himself in the head with his father's handgun, a Glock 33. .357 semi-automatic type. The gun contained an empty magazine, and had one round in the chamber. It was the only weapon owned by the father.

On July 1, 2011 at approximately 10:15pm, the child, while in the company of his father, fatally shot himself in the left cheek. The incident took place in the parents' bedroom where the gun had mistakenly been left on top of a dresser. The father called 911 at 10:20pm. [REDACTED], along with the [REDACTED] EMS were dispatched to the home and arrived at 10:27pm. According to EMS, the child was "asystolic" at the scene and was pronounced dead at 10:50pm. An autopsy was completed on July 2, 2011 by [REDACTED]*. The anatomic diagnosis was that of a gunshot wound of the head. The gunshot entered through the left side of the face then fractured the facial skeleton, perforated and fractured the base of the skull, and lacerated the brain and the meninges. The bullet fragments were recovered from the cranial cavity. The direction of the bullet was backward and upward.

Summary of DPW Child Fatality Review Activities:

The Western Region Office of Children, Youth, and Families reviewed all records pertaining to the child's family. Additionally, an Internal Child Death Review meeting was conducted in Allegheny County on July 18, 2011. A report of that meeting was submitted to this office on February 7, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The victim child was born on December 21, 2007. At the time of birth, the child tested positive for the presence of both marijuana and cocaine in his system. As the result of that reading, a report and a subsequent referral were made to the Allegheny County Office of Children, Youth, and Families. The case was accepted for service there in January of 2008. Pending implementation of services, the child was released from the hospital into the custody [REDACTED]. In home services were then provided to the family through June 6, 2008, at which time the case was closed. This case was given an initial risk rating of "moderate". At the time of closure, a second risk assessment was conducted yielding a rating of "Low".

Primary services provided to the family revolved around [REDACTED] counseling through the [REDACTED] agency. In addition to satisfactorily cooperating with that treatment, both the father and [REDACTED]

Circumstances of Child Fatality and Related Case Activity

On July 1, 2011 the three and a half year old child was alone with his father in the parent's bedroom when the incident occurred. The child fatally shot himself in the face with a gun that had been left on top of a dresser in the bedroom. The child was pronounced dead at the scene at 10:50pm.

It was reported that the father had taken the gun out of the top dresser drawer in the bedroom in order to get a shirt out of that same drawer. At the time, early evening, the family was getting ready to leave the home to attend a softball game. They were said to have been in a hurry and running late. When the family departed the residence, the gun was inadvertently left on top of the dresser.

The family returned home at approximately 10:00pm. At that time, the child's father went to the master bedroom to use the computer while the mother stayed in the living room with the child. The child then joined the father in the bedroom after he had been redirected by his mother several times for throwing a ball in the house.

According to the father, the child sat on his lap in front of the computer for a short time, and then climbed off. The father said that he heard a bang about a minute later, and saw that the child was bleeding from his head. At that time, the father picked up the child and ran onto the porch where he proceeded to call 911 at 10:20pm. Police along with the EMS service were dispatched immediately and arrived on scene at 10:27pm. The child was pronounced dead at the scene at 10:50pm.

The District Attorney's office investigated the incident and decided against filing any charges. Additionally, a investigation listing the father as the was conducted by Allegheny County CYF. The results were that there was not substantial evidence of . Likewise, it was also noted that there was not any " . The investigation was August 25, 2011. Prior to this case being closed, the family was provided with, and took advantage of a referral for grief counseling through Social Services, with whom the family had previously worked.

Current Case Status

This case is no longer active with the Office of Children, Youth, and Families. All treatment goals were satisfactorily met and the case was closed on August 25, 2011.

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 involving a child fatality or near fatality is has not been made regarding the report within 30 days of the oral report . Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report. That review team met on July 18, 2011.

- Strengths: None identified in report
- Deficiencies: None identified in report
- Recommendations for Change at the Local Level: Public education campaign on gun safety recommended as an action step
- Recommendations for Change at the State Level: None made

Department Review of County Internal Report

The county finalized the internal report on February 7, 2012. It was received by the Department on February 13, 2012. The county report is sufficiently thorough, and adequately addresses issues surrounding the death of this child. The county report accurately concludes that the Office of Children, Youth, and Families could not have prevented this death.

Department of Public Welfare Findings:

- County Strengths: The County's timeliness in convening their Emergency Response Team for the death review is viewed as strength as is the diversity in the make-up of the team itself.
- County Weaknesses: None identified
- Statutory and Regulatory Areas of Non-Compliance: None identified

Findings and Recommendations

After reviewing the case record and the Western Regional Office of Children, Youth and Families has concluded Allegheny County Children, Youth and Families followed appropriate protocol in regards to the investigation of this fatality. No areas of statutory or regulatory non-compliance were identified. Since the agency was not involved with the family at the time of the death, it is concluded that the agency could not have prevented this death. The Department supports the county's child fatality team's recommendation to implement a public education campaign pertaining to gun safety.