



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

KayLee Emani Gamble

BORN: 5/16/2010
DIED: 9/27/2010

FAMILY KNOWN TO:
No Private or Public Child Welfare Agency

REPORT FINALIZED ON: August 22, 2011

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 by Governor Edward G. Rendell. 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. Delaware 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> |
|---------------|------------------------|-----------------------|
| KayLee Gamble | Victim Child | 5/16/2010 |
| ██████████ | Mother | ██████/1990 |
| ██████████ | Mother's Cousin | ██████/1991 |
| ██████████ | ██████████ Daughter | ██████/2005 |
| ██████████ | Maternal Great Aunt | Adult |
| ██████████ | Mother's Cousin | Adult |
| ██████████ | Daughter of ██████████ | ██████2005 |
| ██████████ | Maternal Great Uncle* | Adult |

* Resides in Sharon Hill, Pennsylvania, but was in home that night

Other Family not in Household

| | | |
|------------|----------------------|-------------|
| ██████████ | Father** | ██████1981 |
| ██████████ | Maternal grandmother | ██████/1967 |
| ██████████ | Godmother | ██████/1947 |

Notification of Child Fatality:

On 9/27/2010, the county received this report from ██████████ concerning the death of four month old KayLee Gamble. Paramedics were called to the home when the mother found that the child had fallen off the bed head first into a bucket of water that was left next to the bed. The mother and baby had been visiting family at this address. The child had no bruises or marks on the body, and appeared well cared for.

Summary of DPW Child Fatality Review Activities:

The Southeast 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 Caseworker, [REDACTED]. The regional office also participated in the County Internal Fatality Review Team meeting on October 13, 2010.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

This family was not known to any public or private child welfare agencies prior to KayLee's death.

Circumstances of Child Fatality and Related Case Activity:

On 9/27/2010, the county began their [REDACTED] of this fatality, after receiving information [REDACTED]. The mother reported that she had been staying at her aunt's home for about a week. She had placed the child on her aunt's bed (mattress on the floor) during the night. Family members reported that a bucket was placed under an air conditioner that was leaking into the room. The cousin told the [REDACTED] worker that the mother was not aware of the bucket being placed next to the bed. KayLee had been sleeping in her bouncy chair while in this home, but since the aunt was not home this evening, the mother decided to lay the baby in the aunt's bed. When the mother checked on the baby in the morning, she reported that she found the child head first in the bucket of water placed next to the head of the bed. The mother called 911 and attempted CPR. The mother reported to the county worker that "gallons of water" were coming from KayLee's mouth and nose. KayLee was dead on arrival at the hospital. The police secured the home as a crime scene, and would not allow the county worker access until they processed the scene. The police reported to the county worker that the home was cluttered, and had an odor. The family had three cats and two dogs. The police also reported that there was a bucket in the room as well as a leaky air conditioner. No information was provided regarding whether or not the bucket had water when police arrived. The family did report to the [REDACTED] that the bucket had not been emptied for several days.

The county worker responded to the hospital as soon as he received the report from [REDACTED]. Interviews were conducted with the mother and [REDACTED], her adult cousin. The mother explained that she had placed the child on her back in the middle of the queen sized bed about 10 pm. When the child woke up about 2 am, the mother fed her and placed her back on the bed. The mother reported placing pillows and comforters around the edge of the bed. The mother was watching TV with other family members in the living room downstairs. She had fallen asleep and had woken up about 6 am. At that time, she went upstairs

to check on KayLee, which is when she found KayLee head first in a bucket of water.

On 9/30/2010, the worker interviewed the mother and her cousin, [REDACTED] who was watching TV and sleeping in the room where KayLee was laid down. [REDACTED]'s statement contradicted the mother's as he reported that the mother laid KayLee down on her stomach with her head facing the window. [REDACTED] also reported that even though he was in the same room as the baby, he only heard the baby at 1 a.m., at which time he got the mother and she fed the baby.

The Medical Examiner determined that KayLee had water in her lungs.

Current Case Status:

The mother has returned to her mother's home. As she has no other children, no services are being offered by the county. Multiple interviews were conducted with the mother and adult household members. Information provided by family members was contradictory as to how and where the child was placed on bed, and whether pillows were placed around her.

On 11/17/2010, the mother was [REDACTED].

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) 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. Delaware County convened a review team in accordance with Act 33 of 2008 on 10/13/2010.

- **Strengths:**
The county was in compliance with statutes and regulations for the [REDACTED]
- **Deficiencies:**
None identified
- **Recommendations for Change at the Local Level:**
The team identified that medical professionals should review with parents of small children the need for Safe Sleeping Practices and warning signs of Post-Partum depression.
- **Recommendations for Change at the State Level:**
None identified

Department Review of County Internal Report:

The Department is in agreement with the recommendation that medical professionals should review Safe sleeping and post partum depression symptoms with parents of young children, but questions how to implement this.

Department of Public Welfare Findings:**County Strengths:**

- Timely and thorough assessment.
- [REDACTED] completed multiple interviews with the mother during the investigation.
- Good collaboration with police investigation
- Contacted child's pediatrician to assess child's developmental skills

County Weaknesses:

- None identified.

Statutory and Regulatory Areas of Non-Compliance:

- None identified

Department of Public Welfare Recommendation

The Department should engage in dialog with county agencies about developing methods to ensure that parents of young children would receive information about safe sleeping and post partum depression.