



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**REPORT ON THE FATALITY OF:**

**Jamara Stevens**

**Date of Birth: 8/30/2002**

**Date of Incident: 4/05/14**

**Date of Oral Report: 4/05/14**

**FAMILY WAS KNOWN TO:  
Philadelphia Department of Human Services Children and Youth  
PRIOR TO THIS INCIDENT**

**REPORT FINALIZED ON:  
6/23/15**

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, DHS 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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report on May 2, 2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Jamara Stevens	victim child	08/30/2002
[REDACTED]	mother	[REDACTED]/1983
[REDACTED]	sibling	[REDACTED]/1998
[REDACTED]	sibling	[REDACTED]/2000
[REDACTED]	sibling	[REDACTED]/2007
[REDACTED]	sibling	[REDACTED]/2011
* [REDACTED]	father	[REDACTED]/1979

\*indicates that this individual is not a household member

**Notification of Child Fatality:**

At approximately 10 am on 4/5/2014 the youngest sibling to the victim child (VC) found a large caliber hand gun in the home. The gun discharged hitting the victim child in the left arm. The bullet traveled through her chest striking her vital organs killing her. The mother was in the home asleep at the time of the incident. The hand gun belonged to the mother's friend. The gun was not locked away.

**Summary of DHS Child Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. Follow up interviews were conducted with the MDT Social Work Services Manager (SWSM) staff and ongoing SWSM worker. The Southeast Regional Office participated in the Act 33 review on May 2, 2014.

**Children and Youth Involvement prior to Incident:**

On three consecutive days in March 2004, the mother threatened to harm herself and members of her family.

On March 18, 2004, the mother made the children sit outside in the rain.

On March 19, 2004, the mother tried to stab her own grandmother and her brother.

On March 20, 2004, the mother threatened to commit suicide and kill the children. She threw fire into the home. On the same day, March 20<sup>th</sup>, Philadelphia DHS received a [REDACTED] report alleging that the mother was acting in an "out of control manner" by making the children stay outside in the rain. The oldest child reported that his mother beat him. The report was closed out with no findings present. The grandmother filed a restraining order against the mother.

On December 5, 2009, Philadelphia DHS received a [REDACTED] report alleging that the female sibling to the VC was found alone in the home by the police at 5 am. The sibling child was 2 years old at the time of the incident. The police forced their way into the home and found five bags of marijuana, five bags of cocaine and five bags of unidentified pills. The child received a well baby check and was found to be in good health. The child was placed with her grandmother. [REDACTED] The mother was incarcerated at the time of the incident. The report was investigated and findings were present. The family received [REDACTED] from February 12, 2010 thru November 14, 2011.

On March 1, 2013, DHS received a [REDACTED] report alleging that the youngest sibling 16 months at the time of the report was not keeping his well baby visits. Philadelphia DHS was not able to contact the mother because her phone was disconnected. The report was investigated and no findings were presented. The family was opened for [REDACTED]. The services were provided to the family from May 1, 2013 thru July 29, 2013.

On September 12, 2013, DHS received a [REDACTED] report alleging that the youngest sibling 21 months old at the time of the incident ingested hydrocarbon fluid. The fluid is used to light a TiKi torch. The fluid was being poured by the 13 year sibling. The fluid was poured into the child's juice bottle. The parents were not home at the time of the incident. The child was taken to the hospital. The incident was determined to be accidental. The report was closed with no findings present. No services were provided at the time when the investigation was closed.

**Circumstances of Child Fatality and Related Case Activity:**

The VC's mother allowed her male friend to leave his hand gun on top of the refrigerator unsecured and without knowledge of whether it was loaded. The mother described the male friend as someone from the neighborhood who is around during cookouts. The VC's mother stated that she had three drinks and took six [REDACTED] pills prior to leaving the house for the party with the male friend. The VC's mother stated that an older adult cousin provided care for the children while she was out. The 14 year old sibling found the gun and felt that the gun was unsafe on top of the refrigerator so he put the weapon under the younger two year old siblings' bed thinking the younger children would not find it. The next morning the younger sibling discovered the weapon and began playing with the weapon pointing it at the other children making gun sounds as if to shoot them. The VC attempted to remove the weapon from the younger child. When the VC grabbed the weapon, the weapon discharged striking the VC in the arm. The bullet traveled into the VC's chest cavity. The VC's mother was in the bathroom at the time when she heard a pop sound; she had just changed the younger child's diaper. This information came to light during the investigation because initially it was reported that the

mother was asleep at the time of the incident. She found the 11 year old wounded on the floor. The VC's mother reported that she is a trained Certified Nursing Assistant (CNA) performed CPR on the VC until emergency services arrived. At first medical professionals thought that the VC would survive the incident. The VC later died as a result of the wound. The large caliber bullet traveled through the VC's left arm into her chest cavity.

The weapon was a 357 magnum hand gun. The trigger was cocked prior to the two year old sibling finding the weapon underneath his bed. [REDACTED] the VC's mother appeared to blame the 14 year old for the VC's death.

The Philadelphia MDT [REDACTED] was conducted jointly with the [REDACTED] Police Department. The VC's mother was arrested and charged with aggravated involuntary manslaughter and 2 counts of endangering the welfare of a child.

Due to the VC's mother's lack of proper supervision of the children and impaired judgment a safety plan was develop with the VC's mother in agreement. The VC's mother stated that she was distraught and overwhelmed with the recent events. The 2 year old and the 6 year old children were placed with a maternal aunt. The 14 year old was placed in his father's care.

**Current Case Status:**

- [REDACTED]  
[REDACTED] The mother is currently incarcerated at [REDACTED] Correctional Facility on charges of aggravated involuntary manslaughter and 2 counts of Endangering the Welfare of a Child. No charges have been file against the male friend of the mother.
- The 2 year old and the 6 year old sibling are residing with their maternal aunt and receiving kinship care services through a private provider.
- The 14 year old returned to his father's care and continues to visit with his siblings. Philadelphia DHS [REDACTED] and the case was closed.
- All the children are receiving [REDACTED]
- [REDACTED] The 16 year old [REDACTED] on 11/13/2014 into the care of his stepfather [REDACTED].

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

**Strengths:**

- The Act 33 team felt that the MDT SWSM team did an excellent job investigating the case and communicating with the chain of command.

- The Act 33 team felt that the MDT SWSM documentation was thorough, citing all the interactions with the chain of command.

#### Deficiencies:

- The Act 33 team felt concern about the length of service to the family being highly unusual (21 months). The team also felt that both services to the family [REDACTED] were offered through the same private provider netting the same result.
- The team noted concerns regarding the [REDACTED] worker's response to a potential safety issue identified by the intake social work supervisor (SWS) during the March 2013 investigation. The intake SWS became aware of the mother's history of criminal charges related to weapons and wanted to ensure that, if there were weapons in the home, they were safely stored. The intake SWS documented in the Philadelphia DHS case record that she contacted the [REDACTED] agency and requested that they check the mother's home for weapons. At the Act 33 meeting, the [REDACTED] worker reported that they had provided information on gun safety to the mother, however, the worker was unable to recall if she had specifically asked the mother about the presence of weapons in the home.

#### Recommendations for Change at the Local Level:

- The Act 33 team recommended that Philadelphia DHS should review each family for prior service history, including prevention services, when they are referred for services through Philadelphia DHS Central Referral Unit (CRU). This information should be relayed to the agency that will be providing the services to the family.
- The Act 33 team recommended that Philadelphia DHS should consider including a contractual requirement for providers to check their records to see if the agency has previously provided any services to the family. This information must be used to inform service plans and services that the agency provides to the family.
- The Act 33 team recommended that Philadelphia DHS should amend the list of standardized questions that each new worker should ask at their initial contact with the family. The current questions cover general household safety concerns but should also include questions regarding weapons in the home. Philadelphia DHS should also consider defining how workers should respond to the family's answer to the questions. For example, even if a family denies that there are guns in the home, the worker should still discuss gun safety.

#### Recommendations for Change at the State Level:

None Identified

#### Department Review of County Internal Report:

The Department is in agreement with the Act 33 teams recommendations.

#### Department of Human Services Findings:

- County Strengths:  
The investigation and internal report were completed timely.

- County Weaknesses:  
None Identified
- Statutory and Regulatory Areas of Non-Compliance:  
None Identified

**Department of Human Services Recommendations:**

The Department recommends that the county children and youth agencies continue to institute alternatives ways to educate the community on their understanding of what constitutes child abuse and the damaging effects it may have on families and the community.

The Department recommends continuous Gun Safety education with particular emphasis on the effects on young children, including accidental and intentional shooting of innocent bystanders due to the lack of gun safety knowledge in communities.