pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

Orion Lemon

Date of Birth: 03/31/2016
Date of Incident: 06/26/2016
Date of Report to ChildLine: 11/29/2017
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO A COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia County Children and Youth Services

REPORT FINALIZED ON:
06/14/2018

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Philadelphia County did not convene a review team in accordance with the Child Protective Services Law related to this report. The report was determined to be unfounded within 30 days of the report to Childline.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Orion Lemon	Victim Child	03/31/2016
[redacted]	[redacted]	[redacted] 1992
[redacted]	[redacted]	[redacted] 1984
[redacted]	[redacted]	[redacted] 2017

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current investigation notes and gathered information from interviews that were conducted with case worker and supervisor. Hospital records were reviewed and discussion with Law enforcement.

Children and Youth Involvement prior to Report of the Incident:

On 6/26/2016, the Department received information regarding the victim child's death ([redacted]). At the time of the child's death a report was not generated because there were no allegations of abuse. [redacted] reported that the victim child was sleeping, face down, [redacted] with a blanket over him. [redacted] woke up to find the victim child in the same position but unresponsive. [redacted] did not recall rolling on the child. The victim child was pronounced dead at [redacted]. An autopsy was completed. The medical report revealed that the victim child died of natural causes. He was the only child at that time.

Circumstances of Child Fatality and Related Case Activity:

On 11/29/2017, [redacted] contacted the department stating that the victim child died at the hand of [redacted] who intentionally suffocated him. [redacted] stated that [redacted] worked together at [redacted] and began a sexual relationship. [redacted] was residing with [redacted] at the time. [redacted]. [redacted] stated that [redacted] wanted [redacted]. [redacted] stated that [redacted] had verbal disagreements about it. [redacted] moved out and [redacted] moved in. [redacted] stated that [redacted] became sexually abusive making [redacted] do things [redacted] did not want to do. [redacted] stated that at work [redacted] would slap [redacted] in the face a few times and would tell others around that [redacted] was playing. [redacted] moved out and stayed [redacted] for a while but moved back because [redacted] did not have a place to stay. [redacted] stated that [redacted] in bed with the victim child [redacted]. [redacted] stated when [redacted] woke up the baby was not breathing and had a blanket and a jacket over his head. [redacted] was not in the room at the time. The police were called and the child was transported to [redacted]. [redacted] stated that [redacted] was afraid to tell the police what happened.

[redacted] on 3/30/2017 and stated that [redacted] is abusing [redacted]. [redacted] stated that [redacted] was [redacted] by placing blankets over his head while he is sleeping and that he also kicks the basinet. [redacted] also threatens to throw [redacted] down the stairs. [redacted] stated that [redacted] has [redacted]. [redacted] filed a restraining order on 11/20/2017 and left with [redacted]. [redacted] is currently in hiding.

[redacted] was interviewed and stated that [redacted] would never hurt [redacted] child. [redacted] stated that the medical examiner ruled that the victim child died of SIDS. [redacted] stated that [redacted] have issues but [redacted] does not put [redacted] hands on [redacted] or the child. [redacted] stated that [redacted] has some [redacted] issues although [redacted] denies this. [redacted] stated that [redacted] has to attend a hearing as a result of the restraining order.

The Department reviewed the medical files and the police reports. It was determined that the allegations [redacted]. The medical report and the police report stated the child died of natural causes. [redacted] was examined and is doing well. [redacted] was given information for an attorney and information for services to domestic violence programs.

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

- Strengths in compliance with statutes, regulations and services to children and families;

  The County agency completed a thorough investigation to determine the facts of the case by reviewing medical records and police documents. The County was not required to submit a report since an Act 33 meeting was not required. The report was unfounded within 30 days.

- Deficiencies in compliance with statutes, regulations and services to children and families;

  No deficiencies were identified.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

  Continued education [redacted] that co sleeping with [redacted] babies should not occur.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  None Identified

Department Review of County Internal Report:

None

Department of Human Services Findings:

- County Strengths:

  The county agency collaborated well with the hospitals social worker and physicians and the collected all medical reports.

- County Weaknesses:

  None

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  None

Department of Human Services Recommendations:

Continued education on safe sleeping for infants is needed.