Child Fatality Report Release of Information to the Public

Person ID: 112939628

County of Child's Residence: LUBBOCK

Gender: Male

Age: 0 Year(s) 5 Month(s)

Date of Death: 05/13/2024

On the date of the fatality, the child was not in DFPS conservatorship and was living with the child's parent, a managing conservator, a legal guardian or other person entititled to the child's possession.

Child's Name: Harbison,Liam

Current Report(s) of Abuse/Neglect:

Intake Date(s): 5/8/24, 5/21/24 - two reports merged into single investigation.

Summary of Allegation(s)/Investigation:

The Department received a report the deceased child's father returned from work and found the deceased child was still asleep and would not open his eyes. The deceased child was last seen by his father at 6:00 a.m. Around 2:45 p.m., the deceased child's mother and father transported the deceased child to the hospital. He had bilateral hematomas and bleeding in the right eye, which is considered to be non-accidental trauma.

The Department determined the deceased child's mother and father were residing with the deceased child's maternal grandmother. They told law enforcement multiple stories about how the injuries could have occurred. The deceased father admitted he would often place a blanket over the deceased child's face when he cried so that he would not wake the mother. The deceased child's father also admitted he dropped the deceased child on multiple occasions. The deceased child's mother reported she once punched the deceased child, one time, while alone in the room with him. The deceased child's mother also dropped her phone on the him child on a few occasions. The deceased child's grandmother admitted to cocaine use and said she saw the deceased child's father put the blankets on the child's face. The deceased child's grandmother blamed the deceased child's mother for any harm to the deceased child. This indicates the deceased child's grandmother had knowledge of abuse and failed to intervene or report it.

The medical examiner completed an autopsy. The preliminary findings indicated the cause of death as hypoxia with the manner of death non-accidental injury to the brain.

Law enforcement conducted an investigation that is still ongoing when the Department closed its investigation. The

deceased child's mother, father, and maternal grandmother were arrested for charges related to the deceased child's death and were still incarcerated when the Department's investigation closed.

Investigation Findings:

The Department confirmed the deceased child's mother committed physical abuse against the deceased child, which led to his death.

The Department confirmed the deceased child's father committed physical abuse against the deceased child.

The Department confirmed the deceased child's maternal grandmother committed neglectful supervision against the deceased child.

Safety and Risk Assessment Factors Identified:

Case Action:

Only child died

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training

Other Services:

The family accepted information on services in the community.

No Service Referrals and deceased child was an only child.

Other Actions Taken to Mitigate Risk:

None

If one or more children were previously removed from the home, for each conservatorship episode, summarize dates of conservatorship and type of placement at the end of conservatorship:

Not applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 1/20/2024

Summary of Previous Allegation(s)/Investigation:

The Department received a report stating the deceased child was admitted into the hospital in the State of Washington on 1/5/2023 due to a diagnosis of inorganic failure to thrive. The child was discharged on 1/8/24 with a NG tube and currently weighs 6 pounds, 3 ounces. The child's mother and father seemed indifferent to the child and had unclean appearance. The mother and father took out the child's nasogastric (NG) tube, cancelled the home visit scheduled with the dietician, and reported they were moving to Texas to live with the child's maternal grandmother.

The Department determined upon contact with the family, that the child was at the hospital as he throwing up his formula and was constipated. The child was placed back on an NG tube to gain weight and the tube was removed before the family was discharged. The parent's were knowledgeable about the child's health and had followed up with a pediatrician who had no concerns for the child or the family. The hospital and pediatrician both stated the child was developing normally, gaining weight without the NG tube and keeping his formula down. The parents were aware to seek medical care if the child Kristal began throwing up his formula again, stopped gaining weight, or was losing weight. The child was clean each time he was seen and the parents presented with good hygiene and did not smell of any odors any time they were seen. The pediatrician indicated they would contact the Department if they have concerns with the family or if the family misses any appointments.

Investigation Findings:

The Department did not confirm the mother or father committed medical neglect of the deceased child.

Safety and Risk Assessment Factors Identified:
1/20/2024: Safety Assessment - Initial: Safe
Risk Assessment Final Risk Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Parent/Caregiver Training,Basic Needs Support,Medical Resources/Assessment

Other Services:

The family accepted information provided to them on community services and supports.

Other Actions Taken to Mitigate Risk:

None

Other Previous Report of Abuse/Neglect:

Intake Date(s): 1/17/2024

Summary of Previous Allegation(s)/Investigation:

The Department is aware of a report being made to Child Protective Services in Washington State stating the deceased child was diagnosed with Failure to Thrive and discharged from the hospital with a nasogastric (NG) tube to assist with feedings. The parents returned feeding supplies and NG tube last night and reported they are moving to Texas. There were concerns the parents had an odd affect towards the infant.

Investigation Findings:

The case was approved for closure as unable to be complete due to the family not being in Washington State and there being no known return date.

Safety and Risk Assessment Factors Identified:

Risk Assessment: Information not known as this was Out-of-State history.

Case Action:

Closed

Services and Referrals Provided to the Family:

Information not known as this was Out-of-State history.

Other Services:

A report was called into Texas Department Family and Protective Services

Other Actions Taken to Mitigate Risk:

Information not known as this was Out-of-State history.

Note: This report was prepared on 05/12/2026 and does not include corrections or updates, if any, that may be subsequently made to DFPS data on or after the date this report was prepared.