Child Fatality Report Release of Information to the Public

Person ID: 105850840

County of Child's Residence: TYLER

Gender: Male

Age: 0 Year(s) 3 Month(s)

Date of Death: 01/03/2022

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: Greer,Kayden

Current Report(s) of Abuse/Neglect:

Intake Date(s): 01/03/2022; 02/23/2022

Summary of Allegation(s)/Investigation:

The Department received a report after the deceased child was found unresponsive. Law Enforcement and Emergency Medical Services responded, but the child was unable to be resuscitated. Reporter had concerns that father of the deceased child uses marijuana. The Department received another report regarding the two siblings of the deceased child who were in an automobile accident with the father driving. The deceased child's siblings were not restrained in the vehicle.

The Department's investigation determined that father initially stated the child was sleeping alone in his crib. Later the father admitted to co-sleeping on the couch with the child. When the father awoke around 1:40am, he put the child into his crib. The father immediately got deceased child out of the crib and took him to a friend who was staying in the home. The friend said to call 911. The father was well informed about co-sleeping due to the department?s previous involvement regarding a child fatality. The father had another infant sibling to the deceased child die approximately ten months prior due to an unsafe sleep/possible co-sleep situation. The father was also the sibling's caregiver at the time of the death and was provided information about the dangers of co-sleeping and unsafe sleep for infants. The father admitted during his last interview with law enforcement and child protective investigations he was initially dishonest about what happened to the deceased child because he knew this was ?his fault.? The father also admitted to using marijuana and was positive for marijuana in both a urine test and hair test. A gas mask bong

and numerous beer cans were found in the home. The father admitted to smoking marijuana because it makes him forget about all the issues he has. After the second report was received, the Department's investigation determined the father left the siblings of the deceased child, who are 2-years-old and 3-years-old, with a caregiver who did not supervise the siblings. Workers came to the home and found the siblings alone downstairs and the caregiver upstairs asleep with the door closed. The caregiver was difficult to awaken and law enforcement was called. It took it took extreme measures to wake up the caregiver who did not comprehend the safety concerns for the siblings when there is not an awake caregiver.

Law Enforcement has filed charges and is awaiting the convening of the grand jury.

The Medical Examiner conducted an autopsy. The cause of death was occlusion of nose and mouth due to unsafe sleeping environment/ Co-sleeping. The manner of death was accident.

Investigation Findings:

The Department confirmed allegations the father of the deceased child committed Neglectful Supervision of the deceased child, which led to the child's death. The father initial lied about where the child was sleeping and later admitted to co-sleeping with the child. He admitted he was dishonest about what happened and knew it was his fault the child died. The father was well informed about co-sleeping as 10 months prior to the child's death a sibling of the deceased child died due to an unsafe sleep/co-sleep situation.

The Department confirmed allegations the father of the deceased child committed Neglectful Supervision of the older siblings of the deceased child. The father left the siblings with a caregiver who was found unresponsive in a room upstairs with the door closed and the siblings (ages 2-years-old and 3-years-old) alone downstairs. Additionally, the father was made aware by FBSS that he needed new car seats for the siblings since the booster seats were not appropriate. Father continued to transport the siblings without appropriate car seats.

Safety and Risk Assessment Factors Identified:

Structured Decision Making Safety Assessments:
1.) 01/03/2022: Safety Assessment - Initial: Safe with plan

Risk Assessment Final Risk Level: High

Case Action:

Family Preservation

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training,Basic Needs Support

Other Services:

Drug testing and treatment (referred to outpatient services)

Other Actions Taken to Mitigate Risk:

The family was referred to Family Preservation to receive services. After second report was received and found valid, the siblings of the deceased child were removed and placed in foster care.

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:

03/02/2022 - open conservatorship stage. The siblings of the deceased child remain in a foster placement.

Previous Report of Abuse/Neglect:

Intake Date(s): 10/31/2021

Summary of Previous Allegation(s)/Investigation:

The Department received a report that a 2 month old was brought to the hospital by the father of the deceased child due to breathing concerns. It is believed the father was being hypervigilant due to the death of a 3-month-old sibling of the deceased child in February 2021. While at the hospital, a strong smell of marijuana on the father was identified.
sibling.

The Department's investigation determined the father and the mother of the deceased child are not living together. The child and siblings of the deceased child all live with the father who is the primary caregiver of the children. The father admitted to using marijuana, but only when the mother was present at the home. He does not smoke marijuana any longer as the mother sees the children intermittently and has little to do with their day-to-day care. The father admitted to using marijuana to treat his anxiety, but made an appointment with a doctor to be treated with medication prescribed by a doctor.
Regarding the death of the 3-month-old sibling in February 2021, the father admitted the 3-month-old sibling was sleeping with an older sibling of the deceased child. He woke-up when the older sibling was crying and found her sitting on the face of the 3-mnth-old sibling. Emergency services were called, but the 3-momth-old sibling died.

The Medical Examiner preformed an autopsy on the 3-month-old sibling in February 2021. The manner of death was accidental and the cause of death was asphyxiation (suffocation).

Law Enforcement did not investigate as the death was accidental.

Investigation Findings:

The Department did not confirm the allegation the father of the deceased child committed Neglectful Supervision of the 3-month-old sibling of the deceased child. The 3-month-old sibling was co-sleeping with an older sibling of the deceased child.

The Department did not confirm the allegation the father of the deceased child committed Physical Neglect of the deceased child. The home was clean and well stocked with supplies for the child.

The Department did not confirm the allegation the mother of the deceased child committed Physical Neglect of the deceased child. The mother does not live in the home when the report was made. On the day of the incident the mother was sleeping in her car outside of the home.

Safety and Risk Assessment Factors Identified:

Structured Decision Making Safety Assessments:
1.) 12/21/2021: Safety Assessment - Initial: Safe

Risk Assessment Final Risk Level: Moderate

Case Action:

Services and Referrals Provided to the Family:

Other Services:

referred to drug/alcohol assessment, HUD housing, Head Start for daycare services, mental health services

Other Actions Taken to Mitigate Risk:

Siblings are enrolled in the Head Start program. The family is living in HUD Housing.

The father was well educated on the dangers of co-sleeping and the department ensured the family had appropriate sleeping arrangements for the children.

Other Previous Report of Abuse/Neglect:

Intake Date(s):

Summary of Previous Allegation(s)/Investigation:

Investigation Findings:

Safety and Risk Assessment Factors Identified:

Case Action:

Services and Referrals Provided to the Family:

Other Services:

Other Actions Taken to Mitigate Risk:

Note: This report was prepared on 03/02/2023 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.