Child Fatality Report Release of Information to the Public

Person ID: 115541511

County of Child's Residence: HUNT

Gender: Male

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

Date of Death: 11/24/2024

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: Garza,Jonah

Current Report(s) of Abuse/Neglect:

Intake Date(s): 11/24/2024

Summary of Allegation(s)/Investigation:

The Department received a referral stating that the deceased child's father was feeding the deceased child at 1:30am when he began choking on the formula and became unresponsive. Emergency services were called and the father administered cardiopulmonary resuscitation (CPR) prior to their arrival. The deceased child was air flighted to the hospital and found to have severe brain swelling, brain bleeding, and a femur fracture. The father doing CPR could not have caused his injuries and medical personnel believe they are from non-accidental trauma. The deceased child's prognosis was said to be really poor, and he may pass away. It was unknown where the deceased child's mother was when the father was feeding him.

The Department's investigation determined the deceased child's mother and father were currently involved in a legal case regarding the deceased child's older sibling, who was currently in foster care due to numerous broken bones the deceased child's sibling sustained as an infant. The sibling was placed with the paternal great uncle, who lived next door to the deceased child's mother and father. As part of the current investigation, the Department was not able to interview the deceased child's mother or father regarding the deceased child due to the criminal investigation as well as the fact both parents had legal counsel. The information obtained by the Department was from medical records, law enforcement interviews, and autopsy findings. Law enforcement interviewed the deceased child's mother and father after the child's death. On the night of the incident, several people were over for a bonfire. The deceased child was asleep with no issues when the mother left to take the child's maternal aunt home, leaving the child in the sole care of the father. The mother also stopped at a store on the way home for cough medicine and was gone about 30 minutes total. When she returned home, the father reported the deceased child had choked while being fed and he

was using a suction bulb on him.

The mother immediately called 911 and left the phone on speaker for the father to hear CPR instructions and went next door to the paternal great uncle's home since he is a health care professional. The deceased child's father confirmed he was alone with the deceased child when the event occurred leading to his death. He said he sometimes wonders if he woke the child up too aggressively. Law enforcement also obtained video confirming the deceased mother's account of not being home at the time of the incident that led to the deceased child's death. Per medical staff and records, the deceased child was transported to the regional hospital by ambulance, where he went unresponsive. He was resuscitated and placed on a ventilator and then flown to a Children's hospital where tests concluded that the deceased child had widespread brain swelling, scattered areas of brain bleeding, bleeding behind the right eye, retinal bleeding and a questionable femur fracture. Life support was pulled and the deceased child passed on 11/24/2024 at 11:55 pm. Additionally, the autopsy found 19 broken bones in different stages of healing, two broken femurs and head injuries.

The medical examiner completed an autopsy and indicated the cause of death was blunt force trauma, and the manner of death was ruled a homicide.

Law enforcement conducted an investigation and arrested the deceased child's father for Capital Murder of a child under 10.

Investigation Findings:

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

The Department was unable to determine if the deceased child's mother committed physical abuse of the deceased child.

Safety and Risk Assessments not required as only child died.

Safety and Risk Assessment Factors Identified:

Case Action:

Only child died

Services and Referrals Provided to the Family:

Other Services:

No services or referrals provided.

Other Actions Taken to Mitigate Risk:

As part of the sibling's Conservatorship case, the deceased child's mother and father's visitation with the sibling was suspended and a safety plan was initiated in which the paternal great uncle agreed to no contact between the sibling and the parents. The Court also ordered that the mother and father move out of the proximity of the sibling. Law enforcement confirmed that the deceased child's mother and father had moved to another residence.

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:

The deceased child's sibling was removed on 10/07/2023 and at the time of the fatality, was placed with the paternal great uncle. After the death of the deceased child, the deceased child's mother and father relinquished their parental rights to the sibling and Permanent Managing Conservatorship was granted on 01/06/2025. The conservatorship case is ongoing.

Previous Report of Abuse/Neglect:

Intake Date(s): 10/07/2023, 10/07/2023, 10/07/2023 - three reports merged into single investigation

Summary of Previous Allegation(s)/Investigation:

The Department received three reports stating the deceased child's sibling, age 2 months, was taken to the hospital by the deceased child's mother and father due to being fussy. A skeletal survey was completed, and the sibling had multiple broken bones in various stages of healing. The sibling also had an injury/tear in his mouth to the tongue frenulum. The father stated this was done by the sibling by putting his hand in his mouth.

The Department's investigation determined that the mother and father took the sibling to the hospital due to him being fussy. Records indicated there was a scratch under the tongue and a skeletal survey was completed. Nothing was found so the sibling was discharged home. Upon further review of the skeletal survey, numerous new and healing fractures were found, and the sibling was brought back to the hospital upon the hospital's request. The sibling also had a frenulum laceration. The sibling had multiple caretakers including the mother, father, paternal grandfather, paternal great grandfather, and paternal great grandmother. None of the caregiver's could provide any explanation to how the injuries occurred. The father tested positive for marijuana on urine and hair strand drug tests, and the mother was negative on her urine and hair strand drug tests.

A Forensic Assessment Center Network consult was completed which indicated the sibling had an intracranial hemorrhage, retinal hemorrhages, an acute fracturesto his shoulder blade, acute corner fractures on his right and left femur, and a healing left proximal tibia bucket handle fracture. Corner or bucket handle fractures occur at the end of a long bone (bones of the arms or legs), are highly specific for child physical abuse, and caused by forceful traction (such as pulling) of arms or legs. The acute fractures were not due to birth trauma; the long bones showed radiographic signs of healing at about 7 days old, indicating that any acute fracture occurred less than 7 days before the x-rays were obtained. The fractures were not from normal, appropriate, or routine handling of an infant. The frenulum laceration was not consistent with the history provided or the sibling's developmental ability.

Law enforcement conducted an investigation however no arrests had been made at the time the Department's investigation closed.

Investigation Findings:

The Department confirmed an unknown individual committed physical abuse of the deceased child's sibling.

The Department was unable to determine if the deceased child's mother and father committed physical abuse of the deceased child's sibling.

The Department was unable to determine if the deceased child's paternal grandfather, paternal great grandfather, and paternal great grandmother committed physical abuse of the deceased child's sibling.

Safety and Risk Assessment Factors Identified:

Structured Decision Making Safety Assessments:
1.) 10/07/2023: Safety Assessment - Initial: Unsafe

Risk Assessment Final Risk Level: Very High

Case Action:

Services and Referrals Provided to the Family:

Other Services:

The mother and father agreed to complete services and referrals provided to include counseling and evaluation services and parent training as well as services provided in the Conservatorship case

Other Actions Taken to Mitigate Risk:

The Department sought and was granted Temporary Managing Conservatorship of the sibling on 10/07/2023 and at the time of the fatality, was placed with the paternal great uncle. The mother and father were completing services and having regular supervised visitation with the sibling. The mother and father relinquished their parental rights to the sibling and Permanent Managing Conservatorship was granted on 01/06/2025. The conservatorship case was still ongoing at the time the fatality investigation by the Department was closed.

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 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.