IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

EUGENIO S. MATHIS as Personal Representative of the Wrongful Death Estate of JAMES DUNKLEE CRUZ Deceased,

Plaintiffs

vs.

No.

THE NEW MEXICO CHILDREN YOUTH & FAMILIES DEPARTMENT, and JESSICA ETOLL in her personal capacity acting under color of state law; MARVIN PAUL in his personal capacity acting under color of state law; MATTHEW HERNANDEZ in his personal capacity acting under color of state law, MELISSA GARCIA in her personal capacity acting under color of state law and JOHN DOES 1-10, in their personal capacity acting under color of state law,

Defendants.

COMPLAINT FOR CIVIL RIGHTS VIOLATIONS RESULTING IN DEATH

COMES NOW, Plaintiff Eugenio S. Mathis, as Personal Representative of the Wrongful Death Estate of James Dunklee Cruz, by and through his counsel, Rachel Berenson (BERENSON & ASSOCIATES, P.C.), Sara S. Crecca and Alexander D. Crecca (LAW FIRM OF ALEXANDER D. CRECCA P.C.) and brings this complaint for violations of the First and Fourteenth Amendments under the color of state law, resulting in wrongful death. For his causes of action against Defendants, Plaintiff states the following:

JURISDICTION AND VENUE

1. This Court has jurisdiction of the subject matter of this action pursuant to the Court's general jurisdiction and pursuant to 42 U.S.C. § 1983.
2. The Court has personal jurisdiction over the Plaintiff and the Defendants.

3. Venue is proper because Plaintiff and all Defendants are residents of New Mexico. In addition, the Children Youth and Family (State Government) offices are located in Bernalillo, Sandoval and Santa Fe Counties. Further, the acts giving rise to this complaint all occurred in Bernalillo and Sandoval Counties.

THE PARTIES

4. The New Mexico Children Youth & Families Department (hereinafter "CYFD"), is a department of the State of New Mexico, which administers the Protective Services Program by the employees of the Protective Services Division. The Protective Services Division is tasked with investigation of reports of children in need of protection from abuse or neglect and taking action to protect and promote the wellbeing of those children whose safety cannot be assured if they remain at home. As a government agency of the State of New Mexico, CYFD is an entity subject to suit under the Federal Civil Rights Act and 42 U.S.C. § 1983. Plaintiff seeks damages against Defendant CYFD.

5. Jessica Etoll is an Investigator within the Protective Services Division of CYFD. She was tasked with investigating reports of children in need of protection from abuse and neglect, taking immediate action to protect and promote the wellbeing of those children whose safety cannot be assured, ensuring the safety and wellbeing of those children and providing permanent placement in a timely manner. She was also responsible in whole or in part for investigating allegations of abuse and neglect of James Dunklee Cruz from September through December of 2019. Ms. Etoll was a resident of the state of New Mexico (county unknown) at all times relevant to this complaint.

6. Marvin Paul was an Investigative Supervisor with the Protective Services Division of CYFD. He was tasked with supervising the investigation of reports of children in need of protection for abuse and neglect taking immediate action to protect and promote the wellbeing of

those children whose safety cannot be assured, ensuring the safety and wellbeing of those children and providing permanent placement in a timely manner. Mr. Paul was additionally tasked with ensuring the Safety Plans that provided a protective custodial arrangement for abused or neglected children with whom CYFD has a statutory relationship were being followed. He was also responsible for ensuring that the legal division of CYFD initiated an ex parte custody petition in cases where it was unsafe for a child to remain at home. He was responsible in whole or in part for investigating allegations of abuse and neglect of James Dunklee Cruz from September through December of 2019. Mr. Paul was a resident of the state of New Mexico (county unknown) at all times relevant to this complaint.

7. Matthew Hernandez was an Investigative Supervisor with the Protective Services Division of CYFD. He was tasked with supervising the investigation of reports of children in need of protection for abuse and neglect taking immediate action to protect and promote the wellbeing of those children whose safety cannot be assured, ensuring the safety and wellbeing of those children and providing permanent placement in a timely manner. Mr. Hernandez was additionally tasked with ensuring the Safety Plans that provided a protective custodial arrangement for abused or neglected children with whom CYFD has a statutory relationship were being followed. He was also responsible for ensuring that the legal division of CYFD initiated an ex parte custody petition in cases where it was unsafe for a child to remain at home. He was responsible in whole or in part for investigating allegations of abuse and neglect of James Dunklee Cruz from September through December of 2019. Mr. Hernandez was a resident of the state of New Mexico (county unknown) at all times relevant to this complaint.

8. Melissa Garcia was a County Office Manager ("COM") with the Protective Services Division of CYFD for Sandoval County. She was tasked with supervising the investigation of

reports of children in need of protection for abuse and neglect taking action to protect and promote the wellbeing of those children whose safety cannot be assured, ensuring the safety and wellbeing of those children and providing permanent placement in a timely manner. Ms. Garcia was additionally tasked with ensuring the Safety Plans that provided a protective custodial arrangement for abused or neglected children with whom CYFD has a statutory relationship were being followed. As COM she was responsible for ensuring that the legal division of CYFD initiated an ex parte custody petition in cases where it was unsafe for a child to remain at home. Ms. Garcia was additionally responsible for ensuring that her investigators and supervisors were conducting their jobs appropriately and in accordance with the laws of New Mexico. She was responsible in whole or in part for investigating allegations of abuse and neglect of James Dunklee Cruz from September through December of 2019. Ms. Garcia was a resident of the state of New Mexico (county unknown) at all times relevant to this complaint.

9. At all times material to this lawsuit, Defendants John Does 1-10 were residents of New Mexico (counties unknown) and were employed by CYFD. Upon information and belief, they were responsible, in whole or in part, for investigating the allegations of physical abuse and physical neglect suffered by James Dunklee Cruz beginning at his birth through the end of his life on December 10, 2019. Upon information and belief, they were responsible in whole or in part for ensuring James' safety in his home environment, and enforcing the safety plan(s).

10. CYFD, a governmental entity, employed Defendants Jessica Etoll, Marvin Paul, Matthew Hernandez, Melissa Garcia and John Does 1-10 at all times material to this lawsuit. At all times material, each Defendant was acting within the scope of his or her duty as public employees, were state actors and acted under color of state law. At all times material the acts complained of occurred exclusively within New Mexico.

11. Eugenio S. Mathis, Personal Representative of the Wrongful Death Estate of James Dunklee Cruz, is a resident of New Mexico, county of San Miguel.

SUMMARY OF ALLEGATIONS

12. Eugenio S. Mathis, as Personal Representative of the Wrongful Death Estate, brings this lawsuit to recover substantial monetary damages in holding CYFD accountable for breaching its duty to protect James Dunklee Cruz. CYFD knew James was in danger beginning just days after his birth and continuing throughout the four (4) years of his life.

13. The primary purpose of CYFD is to protect New Mexico's children for whom it receives referrals of abuse and neglect from private harm. Its stated mission is to "improve the quality of life for our children." See https://cyfd.org/about-cyfd/vision-mission-principles. CYFD policy specifically provides that "[i]f the safety of the child is ever in conflict with the preservation of the family unit, the child's need for protection takes precedence." See PR 8.10.3.10 (5.1).

14. Beginning in 2018 and through the end of 2019 the agency began a "push" to decrease the number of children taken into the legal custody of the State of New Mexico. The new policy strongly favored keeping children home with family or relatives with voluntary supports to mitigate the identified risks versus initiating an ex parte custody order to begin a legal action against the child's caregivers.

15. This shift in policy was solidified with the 2019 roll out of the agency's new "safety decision making" tool. The new tool's methodology, sometimes referred to as "safety organized practice" was presented to staff as a shift in mindset in favor of the policy that fewer children in custody was not just better for children and families, it was a mark of the agency's success.

16. For James Dunklee Cruz, this shift in policy had a fatal result. Over thirteen (13) referrals of abuse and/or neglect came in from the community, including hospital staff, friends, family and

neighbors of James' mother, Krista Cruz ("Krista") causing at least nine (9) separate investigations to be initiated regarding his physical and emotional safety.

17. Each time CYFD was notified of allegations of abuse or neglect against James, CYFD breached its duty to protect him, and failed in its statutory obligation to conduct a thorough investigation and to maintain a safe home environment for James.

18. CYFD had years of institutional knowledge, medical records, history and documentation about James' mother, Krista, as she had been in foster care herself for seven (7) years. This was all relevant collateral in each investigation, but it was ignored.

19. CYFD was Krista's legal guardian when James was born.

20. As Krista's legal guardian, CYFD was the custodian of seven years' worth of documentation of her significant mental health issues, history of trauma due to sexual abuse, involvement in domestic violence relationships and inability to regulate her emotions.

21. CYFD also knew that it had received previous referrals regarding Krista and her firstborn son, H.M. during 2014.

22. Over the span of his four years of life, CYFD Investigators repeatedly failed to rely on accurate and well-documented facts when it utilized the agency's Safety Risk Assessment Tool, causing its repeated contacts with James to result in flawed and underestimated risk assessment and flawed decision-making resulting in James' death.

23. In addition, for each and every investigation, CYFD failed to follow its own policies by conducting required interviews, making required collateral contacts, searching criminal histories of caregivers and formally documenting unreported allegations of abuse.

24. These failures resulted in flawed safety decisions by Defendants and unsafe living environments for James even while CYFD and Defendants exercised authority over where and with whom he lived pursuant to its multiple written "Safety Plans" and verbal directives to Krista.

25. CYFD's and its employees' multiple failures over the span of four (4) years resulted in years of physical, psychological, and emotional abuse for James, culminating in a harrowing final three months of life.

26. CYFD policy provides that the investigator, in consultation with the supervisor and COM seeks custody of children when the child is unsafe and an in-home safety plan is insufficient to protect the child:

> "[t]he investigation worker seeks or accepts custody of children, including Indian children who live off-reservation, when based upon the professional assessment of the investigation worker, the child is "unsafe" and an in-home safety plan is insufficient to protect the child. Removal may occur at any time during the investigation when the worker, in consultation with supervisor, the county office manager (COM) and the children's court attorney (CCA), concludes the circumstances surrounding the abuse or neglect pose an imminent danger to the child. A child can only be removed by a law enforcement officer or through court order, unless the child is already in the custody of PSD." PR 16 (implementing 8.10.3 NMAC).

27. Defendants CYFD, Etoll, Garcia, Paul, Hernandez, and John Does 1-10 failed to properly execute CYFD policy for appropriate Safety Planning, instead leaving Safety Plans open-ended instead of only for a maximum of twenty-one (21) days, and failing to follow through on each plan's action steps for mitigating the dangers present in James' home environment.

28. On October 18, 2019, James was treated at Duke City Urgent Care for penile bruising, a shoulder injury, neither of which he could have sustained by himself. In addition, James was observed to be covered in multiple bruises and cuts.

29. CYFD responded to this "emergency" level physical abuse referral from medical personnel by dispatching an on-call investigator. Despite this having been the thirteenth (13th) referral for

abuse or neglect over James' lifetime, the fifth referral in just over a month, in spite of his numerous documented physical injuries and the concerns raised by healthcare professionals, CYFD placed James in a five-day respite placement instead of initiating formal legal custody of him.

30. On October 22, 2019, Defendant Etoll observed James make shocking disclosures in a forensic interview arranged by CYFD. As James was interviewed, he had serious penile bruising, his body was covered in bruises painstakingly documented by CYFD and medical personnel days before, and his arm was in a sling. Ms. Etoll listened as James specifically disclosed that his mom, Krista Cruz, was physically abusing him, that his Mom's roommate, Zerrick Marquez, was abusing him repeatedly, including severely bruising his penis and burning him with hot water, and that Krista's other roommate, Pamela Esparza, was physically abusing him with a shoe and a brush.

31. Even though Ms. Etoll informed her supervisors, Matthew Hernandez, Marvin Paul and Melissa Garcia, about these disclosures and begged them to initiate legal custody of James, the next day they determined that James could safely reside with his mother on yet another Safety Plan, and they returned him to her, in conscious disregard for his safety.

32. Only probable cause to believe that a child is being abused or neglected is required to obtain an ex parte custody order in Children's Court. The Rules of Evidence do not apply to the issuance of an ex parte custody order. See 32A-4-16 (A) - (C) NMSA 1978.

33. The Children's Code provides two separate bases for legal custody of a child where the parent is intentionally or negligently leaving the child in the care of another abusive adult, but is not necessarily abusing the child themselves. See 32A-4-2 (B) (1) & (B) (4) NMSA 1978.

34. These laws were clearly established at all times material to this complaint.

35. Within twenty-four (24) hours, Krista was in violation of the Safety Plan and Defendant Melissa Garcia directed Etoll to locate James and for the purpose of finally initiating formal legal custody of him.

36. No one at CYFD ever saw James again.

37. Forty-eight (48) days later, on December 10, 2019, while Krista was at work, James was found brutally beaten to death by Zerrick Marquez, the abuser James had specifically identified to CYFD no fewer than three separate times.

38. James suffered emotional neglect, psychological abuse, malnourishment, sexual abuse, overwhelming physical abuse and torture and died as a direct result CYFD's nine (9) failed investigations, three unenforced Safety Plans, thirteen (13) community referrals and the conscience-shocking decision to return James repeatedly to a home it knew to be objectively unsafe.

FACTS & ALLEGATIONS PERTINENT TO ALL CLAIMS

39. James Dunklee Cruz [hereinafter "James"] was born on January 17, 2015, to Krista Cruz [hereinafter "Krista"]. At the time of James' birth, his mother, Krista Cruz ("Krista"), was a 17-year-old young woman whose legal guardian was CYFD, as she had been removed from her own parents and in foster care herself since she was eleven (11) years old. James was her second child. Krista lost legal custody of her first child to the paternal relatives not long after his birth. Krista Cruz spent her pre-teen and teen years (ages 11 through 18) in the custody of CYFD.

40. The Department had custody of years' worth of institutional knowledge and documentation of Krista's mental health diagnoses, sexual abuse trauma, trauma from numerous placement changes in foster care, and it was aware of the impact that having a child welfare agency as a legal guardian during her teen years had on her ability to parent her young child.

41. CYFD oversaw Krista's placement in in-patient treatment centers and treatment foster care homes to address her significant mental health issues throughout the seven (7) years it served as her legal guardian.

42. CYFD is tasked with providing an array of prevention, intervention and rehabilitative services to New Mexico children and their families.

43. The New Mexico Children's Code requires CYFD's Protective Services Division to receive and investigate reports of children in need of protection from abuse and/or neglect by their parent, guardian or custodian and to take action to protect those children who safety cannot be assured in their home.

44. One of the purposes of CYFD is to intervene when a parent is unable or unwilling to safely parent a child and rehabilitate both the parent and the child via services, and a court-approved treatment plan.

45. The Children's Code further provides that after completion of an investigation of a report of abuse or neglect, the Department *shall* either recommend or refuse to recommend the filing of a Petition for legal custody. 32A-4-4 (C) NMSA 1978 (emphasis added).

46. Children who are subject to abuse or neglect that is reported to CYFD, particularly those who do not yet attend school (aged under five (5) years old) are totally dependent on the Department for their protection. CYFD's risk assessment tool recognizes the increased vulnerability of children under the age of five (5).

47. Each of these laws was clearly established at all times material to this complaint.

48. Children for whom CYFD receives a referral of suspected abuse have a fundamental right to be free from sexual abuse, physical abuse, and psychological abuse in their homes.

CYFD's First Failed Investigation

49. On January 18, 2015, just days after his birth, Defendant CYFD received a report that James was not being properly supervised and was being emotionally abused by Krista.

50. CYFD had fielded more than one referral regarding Krista's ability to parent her firstborn child, H.M. in 2014.

51. These prior referrals were specifically noted in James' investigation as was Krista's history in foster care.

52. CYFD also knew that it had received twenty-two (22) referrals regarding Krista's mother, Sandra Lowe, for physical abuse, physical neglect, excessive discipline and educational neglect of Krista and her other children.

53. CYFD knew it had substantiated six (6) of those referrals and that a Court had terminated Sandra Lowe's parental rights to Krista, on CYFD's Petition in 2009 when Krista was twelve (12) years old.

54. CYFD was the legal guardian of Krista from the time of James' birth through February 18, 2015, when she reached the age of majority.

55. An investigation was conducted regarding the January 2015 referral.

56. CYFD accepted Krista's explanation that she would be living with Sandra Lowe in order to rely on Ms. Lowe's assistance in parenting newborn James.

57. Sandra Lowe's own history of abuse and neglect of Krista and Krista's siblings should have immediately precluded her as James' co-caregiver pursuant to well-established CYFD policy.

58. In addition, when investigators visited Sandra Lowe's house they found that the house was too dirty to be a safe living environment for James.

59. CYFD accepted the house as suitable within twenty-four (24) hours of the home visit.

60. CYFD exercised its authority as a child welfare agency to direct parents whom it is investigating for allegations of abuse or neglect to participate in services to ensure that children remain safe in their home environment.

61. Krista was directed by CYFD to seek various support services, including parenting classes and other support from PB&J, an organization that assists at-risk children and families for counseling.

62. Krista did not complete these classes or the recommended services.

63. During its investigation the CYFD worker did not include key facts, of which CYFD was aware, when answering questions in the agency's Safety and Risk Assessment Tool, including; a previous CYFD report regarding the safety of Krista's first child while in her care; (a) Krista having lost custody of her firstborn child in a civil legal proceeding; (b) Hospital staff's concerns that she was not bonding with or properly feeding James; (c) Krista's history of substantial and durable mental health diagnoses; (d) the cycle of abuse and generational trauma between Krista and her mother, Sandra Lowe, whose parental rights to Krista were terminated at CYFD's urging; and, (e) the risk Sandra Lowe's own long history of abuse and neglect posed for newborn James' safety.

64. CYFD's failure to properly assess and rely on critical facts in its possession when determining risk to James violated policy and resulted in an agency finding that the report of abuse and neglect was 'unsubstantiated" leaving James in the care of Krista and Sandra Lowe.

65. This was the first of at least nine (9) breaches of CYFD's duty to properly assess the risk of James' home environment, to exercise its clear authority to ensure that he was placed in a safe home environment, and to initiate formal legal custody proceedings.

CYFD's Second Failed Investigation

66. On or about March 15, 2015, there was another report to CYFD regarding James. This report implicated possible medical neglect and other abuse by Krista.

67. The reporter indicated that they had observed Krista accidentally hit James in the face, leaving a small red mark, and laugh about it as James cried, doing nothing to comfort him. The complaint also alleged that Krista was sleeping all day and allowing Sandra Lowe to be the primary caregiver for James, as well as failing to seek necessary medical care for James, who had been sick repeatedly.

68. An investigator who interviewed Krista confirmed with PB&J that she quit attending the parenting classes she was referred to after the first referral and that she and her boyfriend, James' father, Alexander Dunklee, had a history of domestic violence.

69. The investigator noted that she had support from her mother, Sandra Lowe and her stepdad, with whom she was residing, and that James' needs were being met.

70. Once again, CYFD investigators failed to rely on accurate data based on clear information in its possession in utilizing the agency's Safety Risk Assessment Tool, resulting in an inaccurate assessment of the risk to James' safety and breach of its duty to protect him.

71. Instead, the investigator identified Sandra Lowe as a "caregiver" and utilized the CYFD Safety and Risk Assessment tool to assess Sandra Lowe's fitness as a caregiver and to identify safety threats in her home.

72. Sandra Lowe's own history of abuse and neglect should have precluded her approval as a caregiver, but instead of enforcing its own policy, CYFD concluded there were "No Threats Identified" regarding Sandra Lowe.

73. Investigators also noted that Krista had two previous unsubstantiated reports of abuse or neglect.

74. CYFD also knew that Sandra's own parental rights to Krista were severed at its urging in a termination of parental rights trial in late 2009 due to her long history of educational and emotional abuse, the disintegration of their bond, and Sandra's inability to meet Krista's significant emotional and mental health needs.

75. After conducting the investigation, CYFD unsubstantiated the abuse or neglect complaint, recommending that both of James' parents voluntarily continue to receive services through PB&J, and that both parents complete a mental/behavioral health assessment.

76. Once again, CYFD required that the family enter into these services in order for James to remain in their home, exercising its authority over James' home environment.

77. This was the second breach of CYFD's duty to ensure James' safe living environment.

CYFD's Third Failed Investigation & First Failure to Enforce the Safety Plan

78. On or about August 7, 2015, CYFD received another report regarding Krista physically neglecting her son James.

79. This was the third report since James was born. He was seven (7) months old, an age that requires significant supervision and support from a nurturing caregiver.

80. The allegations in this community referral were that Krista was not interested in taking care of her child, as evidenced by the amount of time she spent out of the home without the baby or else locked in her room without him, and that there was pet excrement all over the floors of the home.

81. The source also reported that James was observed to be left alone in a baby seat on the couch unattended and at risk for falling off of the edge.

82. Upon information and belief, a fourth report to the Department was made regarding the condition of James' home around this same time period.

83. CYFD opened an investigation and found that the living environment for James posed a threat to James' health, in part, because the stench in the home was unbearable.

84. The investigator observed dog feces throughout the home on the floor, there was trash, old food, food in bowls and plates in Krista's room and all over the kitchen counters. There were roaches scrambling all over the house.

85. CYFD determined that the home was "unsafe" and substantiated neglect by Krista.

86. CYFD held a Family Centered Meeting ("FCM") on August 27, 2015 where CYFD determined that, despite concluding the home was unsafe, and identifying numerous concerns regarding Krista's ability to parent, James would remain in the home with a CYFD Safety Plan.

87. CYFD Policy in effect at all times material to this complaint defines "Safety plan" as; " a document that identifies the strategy or group of strategies implemented to control a safety threat. *It is an intrusion into family life* in the form of ongoing assessment and specific strategies designed to match the duration and level of the safety threat up to and including removal of the child from home." (8.10.3.7 (J.J.) NMAC) (emphasis added).

88. It was contrary to CYFD policy for an investigation to be closed while a safety plan remains active. The investigator must conduct home visits and monitoring of the safety plan to its completion. Policy further provides that if the danger indicators present when the plan was made are not removed within twenty-one (21) days of the Plan's date, another Family Centered meeting "must" take place followed by a "legal staffing" to determine if filing for legal custody of the child is the next step to keep the child safe.

89. The Safety Plan dated August 27, 2015, identified the safety threats as "inadequate shelter, other neglect, condition of the home was unsafe for James, mental health and lack of supervision."

90. Each of these safety threats were also present four years later, when CYFD allowed James to return to his mother's care just before he was killed in his home.

91. The August 2015 Safety Plan noted under "Family Needs" that Krista was to clean the home and complete parenting classes.

92. Under "Family Needs" it also states that "CYFD" is to do the following; "counseling - mental health assessment follow recommendations, infant mental health early intervention, co-parenting-counseling, housing, Life Skills, case management, home visitings, safe place for James until house [is] clean."

93. Under "Concerns" the Safety Plan states "young, parent, immature (16), was in foster care, mom is not engaged in any treatment, recently emancipated as a child from care, Household members have extensive CPS history, Dad currently on juvenile probation, no co-parenting/communication.

94. Krista's sister, Jessica, was approved by CYFD as the "Safety Monitor" and "placement for James at this time" in the Safety Plan.

95. The Department directed Krista to allow Jessica to care for James in Jessica's home until the Department confirmed whether or not Sandra Lowe's home was clean enough for Krista and James to reside there and while CYFD set up the listed services to mitigate the identified safety risks.

96. CYFD further required Krista to engage in its Youth Transition Services ("YTS") and re-engage in case management services. Workers from the Investigations unit as well as a YTS worker would do unannounced home visits to assess risk to James' safety and to assess whether any needed changes should be made to the Safety Plan.

97. CYFD took authority for James' care and home environment, stripping Krista of her right to make decisions about her son's care and authorizing his Aunt Jessica to be his substitute caregiver. In addition, Krista was to complete a laundry list of tasks in order for the safety plan to be removed and the investigation closed.

98. Krista, Jessica Lowe, and CYFD Investigator Misti Sarracino signed the safety plan.

99. CYFD Investigative Supervisor Jeromy Brazfield, I-HS worker Stephanie Randolph, and Krista's YTS worker, Richard Gacewski, signed the FCM attendance sign in sheet to indicate their presence at the Family Centered Meeting.

100. As an infant, James was totally reliant on CYFD and its Safety Plan for protection and to ensure that his basic needs were being met.

101. CYFD failed to properly monitor the safety plan to ensure each danger indicator was removed or to initiate legal proceedings to formally remove James from Krista and ensure his immediate and long-term safety.

102. Within approximately one (1) month, CYFD documented that Krista continued to miss meetings with the case management services worker, refused counseling services, missed appointments with the CYFD investigators, and that Sandra Lowe's home had quickly returned to a dangerous state of uncleanliness – each independent violations of the Safety Plan any one of which required the initiation of ex parte custody proceedings by CYFD pursuant to policy and to keep James safe.

CYFD's Fourth Failed Investigation

103. On April 4, 2016, CYFD received a report that James was being physically neglected by Sandra Lowe. This was the fourth referral to CYFD regarding James' safety.

104. An investigation was conducted, this time identifying Sandra Lowe and her husband, Kevin Nelson, as the caregivers for James, again in direct violation of CYFD's policy against relying on caregivers whose rights it has previously terminated to provide safety to a child. CYFD noted that Krista had left James in their care.

105. The investigators noted that Krista was apparently living in Santa Fe and that James' father was not involved in his life.

106. After home visits and interviews with Sandra Lowe, Kevin Nelson and Krista, CYFD unsubstantiated the referral and, once again, failed to initiate legal proceedings for custody of James.

107. CYFD authorized Sandra Lowe to serve as James' caregiver in violation of policy.

CYFD'S Fifth Failed Investigation – Krista Is Criminally Charged with Abuse

108. On February 12, 2018, the Albuquerque Police Department responded to a report of a male and female screaming in their apartment. Krista and her boyfriend, Jesus, were observed to be residing in an apartment with then-three-year-old James.

109. The police and CYFD both interviewed Krista and observed that the apartment was full of feces and smelled like cat urine.

110. The odor in the apartment was so overwhelming that a CYFD investigator had to back out before vomiting. There was trash all over the house and numerous dangerous chemicals within James' reach, including Raid (Roach & Ant Killer) and window washer fluid.

111. James was observed to be living barricaded in his room by animal gates with a brown substance smeared on the wall.

112. James had a bruise on his cheek about a quarter size in diameter which was observed by both CYFD and the police.

113. During an interview in the home on February 12, 2018, it was noted by CYFD and the police that Krista claimed that between her job, attending school, and therapy appointments, taking care of James was overwhelming.

114. Krista Cruz was charged with cruelty to children in Metropolitan Court and an investigation by CYFD was conducted.

115. CYFD and John Does 1-10 breached their statutory duty to initiate formal legal custody of James, who was now three (3) years old.

116. CYFD again failed to rely on accurate data regarding Krista's capacity to protect James and regarding her own abuse of James in the use of its Safety Risk Assessment Tool, resulting in a finding that the risk to James was "moderate."

117. In addition, CYFD and John Does 1-10 failed to follow the agency's policies by conducting required interviews, making required collateral contacts, searching criminal histories of caregivers and formally documenting unreported allegations of abuse.

118. Despite the facts alleged above, the Department substantiated the allegation of physical neglect and CYFD closed the investigation, continuing to allow James to remain unsafe in Krista's care and with no additional skills, resources or support.

CYFD's Sixth Failed Investigation and Second Unenforced Safety Plan

119. On May 23, 2019, CYFD received a report that James had been dropped off at the reporter's home by Jesus, Krista's boyfriend.

120. The reporter noted that James was four (4) years old, had never been potty trained and that he had bruises on his back and on his legs. James also had a very bad diaper rash that was red with dried feces stuck to him. The report also indicated that James needed to see a dentist.

121. The reporter also indicated that James was "full of anger" and did not want to talk to his mother.

122. The reporter further stated that James disclosed he had been hit with a shoe while in Krista's care.

123. The manifestation of James' chronic and unchecked abuse in Krista's care was getting worse and more obvious to the adults concerned about him.

124. According to an Albuquerque Police Department Uniform Incident Report ("Police Report") on June 6, 2019, the police and CYFD were dispatched to the home of Amber Lowe, Krista's cousin, in response to the May 23, 2019, CYFD referral.

125. The Police Report narrative states that Amber Lowe, Krista's cousin, was interviewed in the presence of two CYFD workers. Amber Lowe reported that she had been caring for James since May 23, 2019, when Krista's boyfriend, Jesus, unexpectedly dropped James off at her home. Amber indicated that while Krista was aware that James was in Amber's care, that Krista had not seen James or provided any support for him.

126. The Police Report further states that Lydia, who is also Krista's cousin, observed James to become very upset when Krista's name is mentioned, and that rather than refer to her as his mother, James referred to her as "Ms. Krista." Both Lydia and Amber were very concerned that James was being abused in Krista's home.

127. The Police Report indicates that an officer interviewed and examined James during the June 6, 2019, investigation and found visible marks and bruises on James, and had a lapel recording of his interview with James, where James was heard stating that Krista's boyfriend, Jesus, had caused the abuse.

128. A crime scene specialist was called in to photograph James' bruises.

129. The Albuquerque Police continued their investigation on June 6, 2019 by interviewing Krista at her apartment.

130. According to the Police Report, Krista admitted that Jesus had spanked James on multiple occasions in her presence and that she had to pull James away from Jesus during the abuse. Krista admitted that she did not report Jesus for abuse due to her poor financial status and high level of stress.

131. The Police Report indicates that Krista admitted she was about to be evicted and would be homeless and that she consented to James staying with Amber as part of a Safety Plan.

132. CYFD investigators noted that in an interview with James he disclosed that he was not safe with "Miss Krista," was scared of her "friend" and that he had been hit with a hanger and a brush on his butt. The investigator also noted that James disclosed that he slept in the closet at Krista's house. Notably, the investigator indicated that Krista had been in a violent relationship with Jesus for three (3) years.

133. Jesus Martinez was charged with Child Abuse and Battery as a result of the June 6, 2019 allegations.

134. CYFD substantiated abuse and neglect by Krista Cruz and Jesus Martinez, but incredibly, still did not initiate appropriate legal proceedings to Petition for legal custody of James and ensure his safety.

135. CYFD investigators, once again, failed to rely on accurate data in using its Safety Risk Assessment Tool, resulting in an inaccurately low assessment of risk to James.

136. In addition, John Does 1-10, who were involved with the supervision of the investigation, failed to conduct required interviews, including of Jesus, failed to make required collateral

contacts, to search criminal histories of caregivers and to formally document previously unreported allegations of abuse.

137. John Does 1-10 also failed to override the tool's risk assessment based on known facts; that Krista had exposed James to a partner who abused him, that Krista likely abused him herself per the law enforcement investigation of the February 2018 investigation; that Krista was chronically homeless and, therefore, forced to rely on various friends and neighbors for shelter and for daycare for James while she worked.

138. CYFD knew that James was unsafe with Krista and directed that James be taken into the care and physical custody of Amber Lowe via a Safety Plan that it created.

139. Ms. Lowe was asked by CYFD to obtain a Power of Attorney so that she could have additional authority to serve as James' caregiver.

140. Once again, CYFD exercised its authority to direct where and with whom James lived while failing its clear statutory obligation to initiate legal custody proceedings in Children's Court as a result of its determination that James was in danger if he remained in Krista's care.

141. On June 22, 2019, a report came in to CYFD that while James was staying safely with Amber Lowe per the Safety Plan, Krista Cruz arrived and took James from her care. Amber indicated that she did not know where Krista took James as Krista was homeless, so she also called it in to the police.

142. Amber also texted the CYFD investigator from the June 6, 2019 referral to let her know James was no longer in her care per the Safety Plan.

143. A Police Report, dated June 22, 2019, was created documenting Amber's report to law enforcement over her concern about James' welfare.

144. The Police Report states that law enforcement "advised Amber I could not remove James due to Krista still having her parental rights and CYFD not feeling he was in danger."

145. A CYFD case worker was contacted by police officers who reported that she did not believe that James was in danger if he was with Krista but not with her boyfriend, Jesus Martinez.

146. No other services were recommended for James' safety.

147. CYFD once again breached its duty to properly assess safety risk and to exercise its authority and obligation to protect James from harm by taking him into legal custody of the state.

148. In addition, CYFD failed to enforce the Safety Plan it had created just weeks prior even though the Department knew Krista was violating the plan in multiple ways, and even though its failure to enforce the plan violated policy and statute. Things were about to get even worse for James.

CYFD's Seventh Failed Investigation

149. On September 10, 2019, a community referral notifying CYFD of James' physical neglect, lack of supervision and Krista's willingness to leave James unattended with her roommates came in.

150. The reporter noted that Krista seemed to be having a difficult time and wondered whether there was help for her through CYFD. Members of the community could see what CYFD refused to: that James was unsafe in Krista's care and something terrible may happen if CYFD didn't intervene.

151. On or about September 11, 2019, another referral was made to CYFD when James was found outside of Krista's residence, alone and unsupervised.

152. Earlier that week the Rio Rancho Police Department had come to the residence because James had been found outside alone in the middle of the night. James was four (4) years old.

153. Jessica Etoll was assigned to the case as the investigative worker. Marvin Paul was her direct supervisor and Melissa Garcia was the County Office Manager who directly supervised both Mr. Paul and Ms. Etoll.

154. Jessica Etoll of CYFD conducted an interview with Krista wherein she admitted to leaving James with a friend and then the friend had left James by himself.

155. Krista also admitted to CYFD that "he often leaves in the middle of the night" referring to James.

156. CYFD also learned in this interview that Krista stated she was going to be evicted soon.

157. Lack of consistent housing is one of the indicators of risk in CYFD's own risk assessment tool.

158. Jessica Etoll advised Krista that she needed to get a sliding lock so that James could not get out of the house on his own.

159. Since part of the referral was for drug use, Etoll asked Krista to submit to a drug test, which Krista refused to do.

160. On September 14, 2019 someone who reported that Krista and James had stayed with them called in a referral to CYFD.

161. The caller noted that Krista and James stayed in the caller's home for approximately two (2) weeks around late August and during that time, the caller observed that Krista would call into work claiming she needed to care for James, when she was neglecting James to the point of failing to regularly feed him.

162. After Krista and James moved out, the caller noted observing James around the apartment complex "wandering" alone on a daily basis for hours at a time and would ask people for food.

163. The caller noted that a Rio Rancho police officer had come to the complex that day to do a welfare check and had planned to call in his observations to CYFD.

164. The caller made an independent report noting that Krista had informed the caller that she was planning to lie to CYFD.

165. The caller also noted that Krista spent a recent paycheck on alcohol and had been staying with someone who the caller had observed using methamphetamine outside of the home where James was staying.

166. Things were so objectively dangerous for James that members of the community sounded the alarm three times in five days. Still, CYFD failed to protect James.

CYFD's Eighth Failed Investigation

167. Four days later, on September 18, 2019, a law enforcement officer called in a referral to CYFD after being dispatched to do a welfare check on James.

168. The officer reported to CYFD that James had been found under the stairs at the apartment where he was living with Krista. He was alone holding two teddy bears.

169. The officer's report noted that a "source" at the apartment advised that James had been unsupervised and alone outside for approximately thirty (30) minutes before Krista came out to check on him.

170. On September 19, 2019, a home visit was conducted by CYFD as a follow-up.

171. Jessica Etoll interviewed Krista and determined that James appeared to be dressed appropriately and safe. Krista advised that she would be moving to either another friend's home or to Utah.

172. On September 20, 2019, Krista called the investigator and informed her that she was living with her best friend, Pamela, and that this would be a permanent location.

173. Jessica Etoll advised that she would be conducting another home visit soon.

174. On September 30, October 2, October 10, and October 14, 2019, Jessica Etoll attempted to reach Krista Cruz to schedule a home visit to no avail.

175. CYFD failed to enforce its own obligations under the "Safety Plan" and state law by failing to initiate a legal proceeding to remove James from Krista's care.

176. This investigation was still open and active when CYFD received yet another referral.

CYFD's Ninth and Final Failed Investigation and Third Unenforced Safety Plan

177. On October 18, 2019, James was brought to Duke City Urgent Care multiple injuries, including an injured shoulder and bruising on the shaft of his penis (three bruises) and a black eye.

178. A call was made to SCI to report James' injuries. This report was screened-in and was classified as an "emergency report" of alleged abuse by CYFD Statewide Central Intake.

179. Emergency Reports contain allegations of serious and immediate safety threats involving a vulnerable child and CYFD policy and procedure requires the agency to respond and begin investigating within three (3) hours of receiving the report. 8.10.2.13 (A) NMAC.

180. CYFD investigation notes indicate that James disclosed to a source who then called CYFD, that Krista's boyfriend, Arturo Baca, touched him inappropriately while he was in the shower. James also disclosed to the source who then reported to CYFD that he took a lot of showers with Arturo.

181. Two Sandoval County officers were dispatched to the Duke City Urgent Care to investigate a report of physical abuse regarding James.

182. The Officer's summary to CYFD included details of an interview with Krista at the hospital where she claimed that she did not know anything about the sexual assault James had described

by her ex-boyfriend, Arturo Baca, however, she then noted that she observed the same type of purple and black bruising as well as bleeding from James' penis in August.

183. Krista stated she had accepted James' and Arturo's explanation that the bruising and bleeding on her son's penis was the result of a fall in the park.

184. Krista also reported to the Detectives during this interview that Arturo took showers with James and that ever since they moved to Rio Rancho James had been having night terrors where he would wake up screaming "leave me alone! Don't touch me!"

185. Krista noted that she allowed Arturo to watch James while she was at work.

186. Tiffany Matteucci of CYFD was the on-call investigative CYFD worker who conducted the investigation at Duke City Urgent Care since the assigned worker, Ms. Etoll, was out of the office.

187. Ms. Matteucci took detailed, time-stamped notes of her interactions during this investigation, including her frequent real-time updates to Mr. Paul, Mr. Hernandez and to Ms. Garcia from Duke City Urgent Care. According to her notes she arrived at the Duke City Urgent Care at 3:30 p.m. and continued to investigate at the scene past 9:30 p.m.

188. Her notes were entered into the CYFD data system, making them accessible to Ms. Etoll, Mr. Paul, Mr. Hernandez, Ms. Garcia, John Does 1-10, and any person at CYFD reviewing the file.

189. Ms. Matteucci first met with James alone. James disclosed to her that mom's boyfriend had scratched his penis and body. He identified Pamela Esparza as the person who hurt his arm. He also disclosed that he gets hit on his butt and his leg with a shoe and a brush when he gets in trouble and that Pamela and Zerrick "hit him a long time" and that Zerrick had abused him the night before. He also stated to Ms. Matteucci that Zerrick stepped on him and hit him.

190. James showed Ms. Matteucci the bruises all over his back. She also noticed scratches under his left ear, scratches on his cheek, and numerous marks, scabs and scratches.

191. Ms. Matteucci took photos with her state-issued cell phone of James' bruises.

192. Ms. Matteucci then met with the treating staff at Duke City who reported to her that James had bruising on his penis "for two weeks" and that Krista had previously taken James to the ER claiming it was for a UTI infection. The staff noted to Ms. Matteucci that a UTI does not cause penile bruising and that the injury to James' penis was "traumatic in nature" and that James had disclosed to them that Arturo had touched his penis and would shower with him.

193. Duke City Urgent care diagnosed James with physical abuse.

194. Ms. Matteucci immediately phoned Mr. Paul, her supervisor, to inform him about the disclosures from James and the information from the medical professionals. Mr. Paul advised her to ask Krista for her side of the story.

195. Ms. Matteucci interviewed Krista, who advised that James hurt his elbow in an incident that happened the night before while she was at work and had left James with her roommate, Pamela.

196. Krista said she did not know anything regarding a sexual assault until that day when her son had disclosed something to the doctor regarding her ex-boyfriend Arturo.

197. Krista advised that her son had started wetting the bed again about 3 days prior, so she had to put him back in diapers.

198. Bed-wetting, or "enuresis" is an indicator of sexual abuse.

199. Urinary tract infections in young children are an indicator of sexual abuse.

200. During that interview Krista blamed Pamela and Zerrick's two year old daughter for James' fresh scratches and bruises, stating that a case worker was already involved with helping control the toddler's "violent behavior."

201. Krista told Ms. Matteucci that Zerrick babysits James and will discipline him, further stating that Zerrick will be the "strong male voice James needs sometimes." When Ms. Matteucci told Krista that it was being reported that Zerrick was harming James Krista denied it, blaming both Jesus and Arturo, the ex-boyfriends with whom she also left James.

202. Tiffany Matteucci interviewed Pamela, who reported that CYFD was already investigating abuse and neglect of another minor in Pamela's home. This is significant as it meant CYFD now had multiple investigators examining Pamela and Zerrick's home environment for its suitability and safety for Pamela and Zerrick's young children and for James.

203. Pamela also reported that Krista did not pay enough attention to her son when she was home and was instead on her phone a lot. Pamela also blamed her own two-year-old for James' bruises and scratches. Pamela denied that Zerrick hurt James, and then gave the opposite story that Krista gave – stating that Zerrick does not watch James alone but is instead at work all day.

204. Ms. Matteucci called Mr. Paul two additional times to update him about these disclosures. Mr. Paul reviewed the safety assessment tool together with Ms. Matteucci and based on the information they entered, the tool indicated that "danger indicator 7" was present and Mr. Paul directed her to create a safety plan.

205. In the safety assessment tool Ms. Matteucci created with Mr. Paul's supervision Ms. Matteucci failed to indicate the following, critical facts:

- James was being abused by a caregiver (Pamela, as well as Zerrick, and Krista could not been ruled out as his abuser);

- Domestic violence likely to injure the child was present in the home;
- The child was not subject to community supervision (enrolled in school);
- Serious injury of abuse of the child other than accidental;
- Excessive discipline or physical force;
- Child abuse and/or sexual exploitation is suspected, and circumstances suggest the child may be in imminent danger as a result;
- Caregiver acts toward the child in negative ways that result in severe psychological/emotional harm, and these actions result in child being in danger;
- Caregiver is unable or unwilling to protect the child from serious harm threatened by others;
- Current circumstances combined with information that the caregiver has or likely has seriously maltreated a child in their care in the past, suggest that the child may be in imminent danger;
- Krista's mental health was a "complicating factor" which made it more difficult or complicated to create safety for the child;

206. Indication of even some of the above facts would have caused the safety assessment tool to identify a higher level of risk to James if he remained in Krista's care.

207. Notwithstanding the flawed safety and risk assessment tool, Paul, Hernandez and/or Garcia, as supervisors, could have indicated at any time that an override was in order, immediately elevating the outcome of the assessment to a risk level of "high" based on any of the following factors: (a) sexual abuse case where the perpetrator is likely to have access to the child victim; (b) non-accidental physical injury to an infant; (c) serious non-accidental physical injury requiring

hospital or medical treatment; (d) death of a child as a result of abuse or neglect; (e) confirmed sexual exploitation of a child; or, (f) confirmed labor trafficking of a child.

208. On that same phone call, Mr. Paul directed Ms. Matteucci to update the law enforcement officers present and "ask if they agreed to do a 48 hour hold if [CYFD] was unable to plan with Krista."

209. Ms. Matteucci staffed the case with Mr. Hernandez at 7:02 p.m. and with Ms. Garcia on two separate phone calls at 7:44 p.m. and 8:10 p.m. from Duke City Urgent care. She updated them about the disclosures, her conversations with medical staff and her observations. These updates are carefully reflected in her written notes.

210. Ms. Matteucci also sent real time text updates to Marvin Paul, Matthew Hernandez and to Melissa Garcia. Ms. Garcia texted Ms. Matteucci, directing that she needed to call Ms. Garcia when it was time to safety plan. Ms. Matteucci recalls thinking it was "weird" that the COM had such an interest in the case.

211. Both Mr. Hernandez and Ms. Garcia independently advised her that James could be safe in respite and with the safety plan. Even though, as supervisors, Hernandez, Garcia and Paul were all well aware that CYFD had a strong legal basis for petitioning for custody of James based on his mother's failure to ensure his safety when she left him with Zerrick, particularly in light of the overwhelming physical evidence of current abuse coupled with James' disclosures, Krista's inconsistent stories about the injuries and her documented, repeated decisions to leave him with known abusers in the past. See 32A-4-2 (B) (1) & (B) (4) NMSA 1978.

212. Ms. Matteucci sent the numerous photos of physical abuse that she took on her phone to Ms. Etoll for her review – texting or emailing them via her state-issued cell phone to Ms. Etoll's state-issued cell phone. Etoll shared them with Marvin Paul.

213. Ms. Matteucci let Krista know that James needed to be away from Krista in a respite placement as a result of her investigation and the injuries, and that if they were unable to find a respite provider they may need to take James on a 48-hour hold.

214. Krista reportedly became upset and told Mr. Matteucci that she had been a foster child herself and did not want her son to be placed with a stranger.

215. After several failed attempts to locate a respite provider known to Krista, Ms. Matteucci asked Krista to complete a genogram form that helps identify potential relative caregivers. Ms. Matteucci threatened Krista that if she did not provide this information for the genogram the child would be placed on a 48-hour hold and given by CYFD to strangers.

216. Ms. Matteucci called Mr. Hernandez, her supervisor, and let him know she could not identify a willing and able respite care provider.

217. Notably, Mr. Hernandez connected Ms. Matteucci with the worker assigned to investigate Zerrick and Pamela's home pursuant to a second open investigation regarding the home where James was residing.

218. According to Ms. Matteucci's notes, the APD Officer present indicated that she could continue to stay to see if Krista would cooperate with the safety plan and respite plan, but that if Krista did not, then they needed to do a 48 hour hold for James' safety.

219. The Safety Plan Ms. Matteucci created that night, under the supervision of Mr. Paul, Mr. Hernandez and Ms. Garcia, indicated that "extended family members or network will provide brief respite for the child" as a safety intervention.

220. Notably, the box marked "Legal action planned or initiated" remained unchecked on the Safety Tool and plan. Instead of coordinating with law enforcement to place James on a 48-hour hold and/or finally initiating a petition for legal custody of James via CYFD's legal division,

CYFD once again exerted its authority over Krista and James to direct where James would live without ensuring his long-term safety and well-being by taking him into legal custody of the state.

CYFD's Five-Day Respite Placement for James

221. CYFD policy, which was rolled out for the first time sometime in 2019, allows for a five (5) day "brief respite" to be used in the course of an investigation. This respite period buys the Department time to continue to investigate through required interviews and documentation of collateral information. This is more than double the time period a 48-hour law enforcement hold provides.

222. CYFD located a family Krista identified to provide respite care for James and caused law enforcement officers to transport James to the respite care home.

223. Ms. Matteucci understood that Ms. Garcia, Mr. Paul and Ms. Etoll would continue to investigate the allegations during this 5-day respite period, then decide whether or not to initiate legal custody at an FCM meeting the following week.

224. Ms. Matteucci took a number of steps to ensure the home was a safe placement for James, including (a) inspecting the home for adequate food, safety and an appropriate place for James to sleep; (b) causing law enforcement to run two background checks on the adults in the home to further ensure James' safety; and, (c) ordering the family not to allow Krista to have access to James while in their care; (d) instructing the family to contact CYFD or law enforcement if Krista came to take James, and (e) asking the caregivers to be responsible for taking James to the Para Los Ninos sexual abuse exam (which they did).

225. The Safety Plan specifically stated that James could be "injured again (bruises, marks on the back, penis, face) by an unknown person while in the care of Krista, Pamela and Zerrick especially because it is unknown how he got the injuries."

226. Additionally, CYFD required Krista to sign an authorization so CYFD could gather James's medical records. Krista was required to allow James to submit to a Safe House Interview and an exam by Para Los Ninos to ensure James' safety and learn about additional disclosures.

227. Ms. Etoll obtained Krista's signatures on the releases during a home visit at Pamela and Zerrick's apartment, where Krista was residing with James, on or about October 21, 2019.

228. During this home visit Etoll had to navigate trash piled up at the front of the residence, and the home was cluttered, "filthy" and smelled badly. In addition, Etoll observed that Pamela and Zerrick's own five-month-old child was not being appropriately cared for in the home.

229. Ms. Etoll was so concerned during this home visit about the condition of the apartment and the treatment by Pamela of her own children that she called in a referral to SCI herself.

230. Ms. Etoll reviewed the photos of physical abuse that Ms. Matteucci took at the Duke City Urgent Care with her direct supervisor, Marvin Paul, and the County Office Manager, Melissa Garcia.

231. Ms. Etoll observed that the bruises on James' back were consistent with being hit by a hairbrush.

232. There would be an "Imminent Risk of Removal Family Centered Meeting" on October 23, 2019.

233. On October 21, 2019, James was taken to Para Los Ninos for a "SANE" (sexual abuse medical evaluation) examination. During this exam, he made a number of disclosures to the interviewer.

234. James disclosed that Pamela broke his arm, that he gets hit when he is in trouble including with a shoe on his face and butt, and that his penis was hit with a brush.

235. James also disclosed that his mom hit him.

236. James also disclosed that when one of his male abusers told him to "tell them I hit you" that "my mom said no, we are going to say that" and "I got beat up and I got so mean."

237. When asked if he slept well, or if he had dreams, James responded, "I dream about getting hit and I am not going to get hit again."

238. CYFD and each Defendant was responsible for not only including the Para Los Ninos exam results in its investigation and analysis as critical collateral but also for overseeing James' participation in the exam itself.

239. On October 23, 2019, James Dunklee Cruz was interviewed at the Safe House while Jessica Etoll was present and observed his disclosures.

240. James sat with his arm in a sling and gave very clear, very graphic details of his ongoing, chronic, and current abuse by not only Pamela and Zerrick, but by Krista herself.

241. The single mistake of fact that CYFD had relied upon for four years in its repeated decisions not to initiate formal legal custody of James was now directly debunked by four-year old James himself: his mother *was* abusing him.

242. James not only disclosed that Krista had abused him in the past, but he also specifically stated that she hit him with the brush "still."

243. James also disclosed a multitude of extreme abuses that had been committed by Zerrick specifically – he hit him with "very hard" with a brush on his bare butt, repeatedly burned him with hot water and grabbed his penis, causing it to bleed, more than once.

244. James also disclosed that Pamela hit him all over his face and body and that she popped his arm.

245. Etoll immediately reported the Safe House disclosures she had witnessed to Marvin Paul and Melissa Garcia.

246. Ms. Etoll communicated to both Mr. Paul and Ms. Garcia that it was clear to her that James' life had been filled with abuse, both sexual and physical, by numerous men his mother had left him with.

247. Etoll specifically reviewed the photos Matteucci took of James' bruises and penile injuries with Mr. Paul. Etoll also confirmed that Ms. Garcia had reviewed the photographic evidence of severe abuse.

248. Etoll specifically pointed out to both Garcia and Paul that Krista had violated a Safety Plan she had created in September of 2019 and had stopped responding to Etoll's follow up calls before James wound up at the Duke City Urgent care covered in physical signs of abuse. She was adamant that Krista would again fail to follow their directives in a new Safety Plan. Their response was to ignore Etoll's assessment and send James home to his mother anyway.

249. Both Garcia and Paul knew that Krista and James were residing with Zerrick and Pamela and had nowhere else to go.

250. Immediately following James' Safehouse interview, Etoll also contacted Detective Smith of the Albuquerque Police Department and requested he attend the FCM for the purpose of issuing a 48-hour hold due to the disclosures of severe abuse that she had just heard James make.

251. Detective Smith at first stated that he would attend and issue the 48-hour hold, but later stated that he would not have authority to do this due to "jurisdictional issues between Albuquerque and Sandoval County."

252. Mr. Paul and Ms. Garcia had been trained that any law enforcement officer could sign a 48-hour hold directive, regardless of jurisdiction, and that State Police were regularly asked by CYFD to assist in this effort.

253. In addition, CYFD routinely initiates legal proceedings and, via an Ex Parte Custody Order, removes children from their parent's homes without a 48-hour hold by law enforcement.

254. CYFD did not need the police departments in either Bernalillo or Sandoval County to take any action in order to exercise CYFD's independent obligation under state law to take James into legal custody of the state pursuant to its own policies and procedures as well as the Children's Code. NMSA 1978 §32A-4-4 (C).

255. Ms. Etoll knew James was being severely abused and believed CYFD should immediately take custody of the child but needed her supervisors to cause the CYFD's legal division to initiate the ex parte Petition for legal custody of James.

256. Etoll told Melissa Garcia several times that day that CYFD should take immediate legal custody of James.

257. Etoll told Marvin Paul several times that day that CYFD should take immediate legal custody of James. In response, Mr. Paul, however, told Ms. Etoll to "calm down" and to proceed to the Family Centered Meeting later that day instead.

258. On October 23, 2019, a family centered meeting was held by CYFD.

259. Just before the meeting officially began, and in the presence of Marvin Paul, Etoll had a critical exchange with Krista. Etoll bluntly pointed out to Krista the long list of people identifying her son's abuse specifically by Zerrick including- the police, Etoll herself, James himself, and the medical staff at Duke City Urgent Care. Etoll, knowing her supervisors were making a terrible mistake in sending James back to Krista pleaded with Krista, in Marvin Paul's presence, not to return to Zerrick and Pamela's apartment.

260. Krista's response was to cry and to continue to deny that Zerrick was abusing her son.

261. Then Ms. Garcia joined the group, and the meeting began. Neither Ms. Etoll nor Mr. Paul, both of whom attended this meeting, updated the Safety Risk Assessment tool with the new information obtained at the SANE interview and exam or the Safe House Interview.

262. Ms. Etoll specifically advised Ms. Garcia and Mr. Paul that if CYFD allowed Krista to take James back, she would not only violate the Safety Plan, she would hide James from CYFD.

263. Ms. Etoll told Mr. Paul several times that if Mr. Paul or Ms. Garcia did not approve of taking James into CYFD custody, he would return back into an abusive home with Krista, where he would continue to be abused.

264. On a break during the FCM Etoll took Garcia and Paul aside and pointed out that Krista didn't "fully believe" that Zerrick was abusing James and that it was obvious she would return to Zerrick and Pamela's home. Both Paul and Garcia responded, "let's Safety Plan."

265. Krista's chronic homelessness and reliance on others to care for James while she was at work was clearly at the forefront of Etoll's analysis, but not Paul's or Garcia's.

266. CYFD policy specifically provides that a Safety Plan should only be used when the family is willing to honor it.

267. Upon information and belief, Ms. Garcia and Mr. Paul participated in a staffing with the legal department regarding James' case, per policy, the same day as the FCM.

268. Remarkably, Marvin Paul and Melissa Garcia, who both participated in the FCM, decided at the meeting to return James to Krista's care, trusting her to comply with yet another Safety Plan. They even knew that Krista was going to have Pamela Esparza, one of James' identified abusers, who was also present at the FCM, take Krista to pick up James and then drop them off at the Joy Junction homeless shelter.

269. This time, the terms of the Safety Plan included, among other provisions;

- Krista would not return to Zerrick and Pamela's residence with James;
- Krista would, instead, live with James at Joy Junction, a homeless shelter;
- Krista would seek counseling even though the Department was aware of years' worth of Krista's history avoiding counseling.
- Krista would meet Etoll, in person, the next day at the Starbucks near work.
- Krista would allow James to attend a daycare, at CYFD's expense. They daycare was chosen specifically because it was the only one in Albuquerque, where Krista worked, that would allow children to stay overnight, just in case she needed a safe place to leave James.
- CYFD would provide Krista with hotel vouchers specifically so she could reside somewhere safe with James.
- CYFD provided bus passes so Krista could rely on transportation other than Pamela or Zerrick.

270. CYFD scheduled meetings to help Krista find a more permanent residence.

271. No Petition was filed in Children's Court for the custody of James to ensure his safety and provide James with Due Process, judicial review and advocacy for his safety and welfare.

272. As County Office Manager, Ms. Garcia had the authority to set the ex parte custody procedure in motion pursuant to CYFD policy.

273. As Supervisors, both Matthew Hernandez and Marvin Paul, who often worked in tandem, each had independent authority to set the ex parte custody procedure in motion pursuant to CYFD policy.

274. Neither Mr. Paul nor Ms. Garcia ever directed Ms. Etoll to update the Safety Risk assessment tool with the new evidence of repeated, prolonged physical and sexual abuse or in light of James' multiple disclosures of ongoing physical abuse.

275. Mr. Paul, Mr. Hernandez and Ms. Garcia never advised Ms. Etoll to begin preparation of her affidavit in support of an ex parte custody order, per CYFD policy.

276. Notwithstanding the flawed Safety Risk Assessment tool recommendations, Paul, Hernandez and/or Garcia could have overridden the tool's outcome in his or her capacity as a supervisor. The tool's instructions specifically state that the tool recommendations may be disregarded and overridden by a supervisor in order to protect the child.

277. The moment the FCM concluded Etoll told Paul and Garcia they had made a mistake. Their response to Etoll was "let's see what happens tomorrow," in apparent reference to Krista's obligation to meet Etoll at Starbucks and make arrangements to move from the Joy Junction homeless shelter to a motel.

278. Predictably, on October 24, 2019, the very next day, Krista ignored the Safety Plan, leaving the homeless shelter with James less than 24 hours after arriving, standing up Etoll at the Starbuck's meeting, and failing to respond to CYFD's phone calls or texts.

279. Just one day after allowing Krista to take James back, on October 24, 2019, Ms. Etoll could not locate James and was now frantic about his safety.

280. At Marvin Paul's direction, Etoll asked APD to conduct a welfare check at the residence of Pamela and Zerrick. The plan was to immediately take James into CYFD custody.

281. Ms. Garcia, relenting to Ms. Etoll's pleas, finally advised her that if she could locate James, Ms. Garcia would approve the initiation of the ex parte custody petition regardless of law enforcement's position or availability for a 48-hour hold.

282. APD and Etoll directed the apartment manager to open the door of the apartment to conduct a welfare check and determined that nobody was home.

283. APD officers were sent to Krista's work to locate James, but he was not there.

284. On October 24, 2019, Krista called Jessica Etoll very upset about officers going to her place of employment and Jessica again stated, "that she must follow the safety plan in order to avoid James being placed on a 48-hour hold by the police." Krista advised Etoll that James was with her sister, Jessica, and gave Etoll a phone number to follow up and confirm. When Etoll called the number, it turned out to be a "dummy" phone number.

285. On October 30, 2019, Krista informed Jessica Etoll that both she and James were in Arizona with her Aunt.

286. Ms. Etoll contacted the Aunt who clarified that Krista never came to Arizona but had asked her Aunt to cover for her and that she would like to be a placement for James. During this call both the Aunt and a man Etoll understood to be Krista's biological father were terrified for James' life, and pleaded with Etoll to find him.

287. On November 15, 2019, Krista responded to Jessica Etoll stating that she knew a warrant was going out for her but that she was in Arizona. She also advised that she is tired of being harassed by CYFD and that she was not with Pamela or Zerrick.

288. On December 10, 2019, Emergency Medical Services were dispatched to the home of Pamela and Zerrick where James and Krista Cruz had been living.

289. Zerrick claimed he had been babysitting James when he found him lying on the floor non-responsive.

290. On December 10, 2019, James Dunklee Cruz was brought to UNMH in cardiac arrest, with respiratory failure and intracranial hemorrhage due to severe abuse.

291. Just minutes after his arrival at UNMH, James Dunklee Cruz died.

292. James had been severely and brutally beaten to death.

293. The Office of the Medical Investigator conducted an autopsy that found James died of multiple blunt force injuries including trauma to his head, his torso, his upper extremities and his lower extremities.

294. A CT scan of James' head and neck revealed a subdural hematoma, a mild subarachnoid hemorrhage, large right scalp hematoma, smaller posterior parietal scalp hematoma, subcutaneous soft tissue swelling of right neck.

295. A CT scan of James' body revealed lung injuries and a Grade V liver laceration.

296. The autopsy also revealed healing jaw fractures and healing subdural hemorrhage indicating significant blunt head trauma that occurred "at a time much earlier (weeks) than the acute injuries."

297. James can be seen in the Safe House video interview and the law enforcement lapel footage from Duke City Urgent care forty-eight (48) days prior moving his jaw left and right – potentially indicating the healed fractures observed in his early December autopsy were present at that time.

298. The cause of death was homicide.

299. Zerrick Marquez has since plead guilty to Intentional Child Abuse Resulting in Death and is facing life in prison for James' murder.

300. At least three investigations regarding James assigned to Ms. Etoll were ongoing and remained open at the time of James' death, as did the two investigations regarding Pamela and Zerrick's home environment, where James had clearly been living.

301. CYFD opened a new investigation after his murder.

302. On or about Tuesday, December 10, 2019, Ms. Etoll was informed by Mr. Paul and Ms. Garcia that James Dunklee had been killed.

303. Ms. Etoll had given her two-week notice in late November to CYFD that she was leaving her position as investigator, and the week of James Dunklee's death happened to be her last week of employment.

304. On that same day, Ms. Garcia and Mr. Paul asked Ms. Etoll where her notes regarding each of the Dunklee investigations were.

305. Ms. Etoll advised Ms. Garcia and Mr. Paul that her notes were in a word document, and she had not yet formally entered them into the CYFD FACTS data system.

306. Mr. Paul and Ms. Garcia advised Ms. Etoll to find the notes in her computer, print them and to give them copies to review prior to entering them into the FACTS data system. They further advised her that her "only" task that week was to get these notes in order and entered into the data system after their review.

307. Mr. Paul and Ms. Garcia proceeded to review Etoll's notes, directing her to make a large number of substantive deletions and edits prior to entering them into the data system. Once notes are entered into the FACTS system they become part of the case file permanent record.

308. Garcia and Paul spent days reviewing and directing Etoll to edit her notes regarding James' September and October 2019 investigations.

309. On Wednesday, December 11, 2019, Mr. Paul texted Ms. Matteucci about James' death. First, he confirmed that he was aware and concerned about future litigation and agency liability stating to Ms. Matteucci "you will be called to testify."

310. Upon learning of James' death, both Defendant Paul and Defendant Garcia immediately understood that their actions and inactions in his CYFD case violated the law and they set out to cover up their mistakes.

311. Mr. Paul specifically acknowledged in his December 11, 2019, text exchange with Ms. Matteucci that they should have taken James into custody on or after the Duke City Urgent Care call out. When Ms. Matteucci indicated James should have been taken into custody the night of the Duke City Urgent care call out, Mr. Paul responded "we all feel that way."

312. Garcia and Paul knew that their conduct had put James at substantial risk of serious, immediate and proximate harm because he was killed by the man he had named to them repeatedly as his abuser. Exactly as Ms. Etoll had predicted to both of them, Krista had taken James back to her residence with Zerrick and Pamela where he was beaten until he died.

313. Garcia and Paul also knew that as supervisors, their decision making was of particular concern in any future litigation. Both Garcia and Paul caused material notes, observations and conclusions recorded by Ms. Etoll to be destroyed to avoid their use as evidence of the agency's liability.

314. Etoll complied with the edits, realizing after the fact that her supervisors were not trying to ensure that every base was covered in the case history, they were "suppressing my notes" and "trying to cover themselves while not considering my future."

315. Ms. Garcia, Mr. Paul and Ms. Etoll and John Does 1-10 violated their statutory obligation to keep an accurate record of the facts gathered pursuant to each and every investigation of suspected abuse or neglect regarding James Dunklee Cruz preserved and contemporaneously entered into the CYFD permanent data system.

316. Ms. Etoll communicated via her CYFD-issued iPhone in carrying out her duties as an investigator for each investigation she was assigned regarding James Dunklee Cruz in 2019.

317. Ms. Etoll never erased any data from her phone from these investigations, including photos she took and/or received of James, James' injuries, and James' home environment, and of direct communications via text and email with both Mr. Paul and Ms. Garcia about the case.

318. Mr. Paul and Ms. Garcia directed Ms. Etoll to erase the portion of her notes that stated that Ms. Garcia told Ms. Etoll on or about October 24, 2019, the day after CYFD allowed Krista to take James back from respite care, that Ms. Garcia would finally approve the ex parte custody procedure to begin the process of taking James into CYFD custody.

319. Upon information and belief, Ms. Garcia and Mr. Paul also directed Ms. Etoll not to indicate in the FACTS data system that it was Ms. Etoll's opinion that James should have been taken into custody at the October 23, 2019, Family Centered Meeting.

320. Mr. Paul and Ms. Garcia also directed Ms. Etoll to erase the portion of her notes that stated that Detective Smith had initially agreed to attend the October 23, 2019, Family Centered Meeting for the purpose of taking James into a 48 hour hold in anticipation of CYFD causing the ex parte legal custody proceedings to begin.

321. The original and unedited copy of Ms. Etoll's observations and conclusions during her investigations was saved on the hard drive of her work computer. Ms. Etoll did not save a hard copy.

322. Ms. Etoll followed the directives of her boss, Marvin Paul, and his boss, Melissa Garcia, and made the material changes to her notes prior to entering the data into FACTS.

323. On December 13, 2019, the Friday after James' death and Ms. Etoll's last day as a CYFD employee, she turned in her state-issued iPhone, which contained photos, text messages to and from Krista, Marvin Paul, Melissa Garcia, Tiffany Matteucci and others pursuant to her investigations. Ms. Etoll never erased any of that data prior to turning her phone in to CYFD.

324. Ms. Etoll gave Mr. Paul and Ms. Garcia the passwords to the iPhone and the desktop computer she used during the Dunklee investigations.

325. Upon information and belief, CYFD caused a "factory reset" of Ms. Etoll's phone to occur, rather than preserve this material evidence, even as the agency was opening its own investigation into James' death.

326. Upon information and belief, CYFD caused Ms. Etoll's work computer to be reset, erasing the only copy of her investigation notes that were not redacted and revised by her supervisors Marvin Paul and Melissa Garcia to eliminate direct evidence of CYFD liability.

327. Upon information and belief, CYFD caused Tiffany Matteucci's work computer and phone data to be "factory reset" at the conclusion of her employment, potentially destroying all traces of the numerous photos of the physical evidence of James' abuse, her communications with each of the named Defendants, and her opinions as an investigator responding to the Duke City Urgent Care call out.

COUNT I: CIVIL RIGHTS CLAIMS AGAINST CYFD, JESSICA ETOLL, MARVIN PAUL, MELISSA GARCIA, MATTHEW HERNANDEZ AND JOHN DOES 1-10 DENIAL OF ACCESS TO COURTS

328. All previous allegations are incorporated by reference as if fully set forth herein.

329. CYFD, Defendant Garcia, Defendant Hernandez, Defendant Etoll, Defendant Paul and John Does 1-10 relied on Safety Plans and verbal directives regarding James' home environment in order to bypass the formal legal custody process. This resulted in Defendants assuming functional custody of James in a matter unreviewable by the Children's Court. This denial of James' due process right to court access occurred on at least three separate occasions during his life.

330. Safety Plans were created at the conclusion of numerous investigations into allegations of abuse and neglect regarding Krista's ability to care for the child including but not limited to the following dates: during the August 7, 2015, investigation, the May 23, 2019, September 11, 2019, and October 18, 2019, investigations and at the October 23, 2019, Family Centered Meeting.

331. Each of these written Safety Plans, signed by CYFD employees and by Krista, set forth the unilateral terms under which CYFD would allow Krista to retain legal custody of James and the breach of which was supposed to result in an ex parte custody proceeding.

332. Had CYFD followed professional standards and/or its own policies and followed up on James' safety each time his mother breached a Safety Plan, an ex parte custody Petition would have been initiated by CYFD during any number of the nine investigations and James would have been afforded his due process right to access the Children's Court protections, proceedings, and supervision.

333. Per CYFD policy, a Safety Plan is a short-term, detailed set of action steps to control dangers identified on the safety assessment. It is made when the safety assessment shows one or more danger indicators AND both the family and CYFD believe the child(ren) can safely remain in the home with this plan. These plans can last up to 21 days and included a detailed plan (action steps, not services) for mitigating the danger; the presence of a network to participate in the plan; and a way to ensure the plan is working. See 8.10.3.10 NMAC.

334. In addition, CYFD policy specifically provides that in order for a safety plan to be considered, the caregiver must be able to demonstrate the following: capability of participating in an in-home safety plan; willingness to participate in an in-home safety plan; *and* can identify at least one supporting adult who was not involved in the allegations, who is also willing to participate in a safety plan for the family. PR 8.10.3.16 (emphasis added).

335. Defendants failed to assess Krista's safety-planning capacities at each and every phase of the nine (9) investigations.

336. Defendants failed to enforce each of the at least three (3) distinct Safety Plans' action steps for mitigating the danger to James resulting in his chronic, repeat abuse, neglect and maltreatment and finally his death.

337. Defendants failed to ensure any of the three Safety Plans were working to reduce or mitigate the harm he was repeatedly and predictably experiencing, resulting in his chronic, life-long abuse, neglect, maltreatment and, ultimately, his death.

338. The October 23, 2019, Safety Plan, and its requirements for Krista to keep James safe in his home environment and two investigations remained open at the time of his death.

339. Instead, CYFD relied on the Safety Plans as a way to honor the agency's push in 2019 to reduce the overall number of children in state custody – creating an illusion of safety for James while hitting its mark on lower numbers of children in care.

340. These safety plans were relied upon by Defendants as a type of functional custody where it directed the specific parameters of James' home environment without expending the resources to take legal custody of him. The terms of these Safety Plans make this functional custody relationship self-evident: the Safety Plan created from the August 7, 2015, investigation, among other directives, identified James' Aunt Jessica as his "substitute caregiver" and "placement." The May 23, 2019, Safety Plan, among other directives, identified James' Aunt Amber as his substitute caregiver and the agency directed her to obtain a Power of Attorney over James. The October 18, 2019, Safety Plan, among other directives, authorized a 5-day placement for James which was fully vetted by CYFD via a home visit and background checks. The October 23, 2019, Safety Plan,

among other directives, directed that James could no longer live with Zerrick and Pamela, and that Krista had to move residences, seek counseling, and stay in touch with CYFD to keep James safe.

341. This kind of open-ended custody determination normally can be made only in a manner consistent with, and governed by, the requirements of the New Mexico Children's Code. The stated purpose of this comprehensive statutory scheme is "to provide judicial and other procedures through which the provisions of the Children's Code are executed and enforced and in which the parties are assured a fair hearing and their constitutional and other legal rights are recognized and enforced." NMSA 1978 § 32A-1-3 (B).

342. Had Defendants Jessica Etoll, Marvin Paul and Melissa Garcia or John Does 1-10 adhered to the requirements of the Children's Code and sought to formally remove James from his unsafe living environment on any one of the allegations of abuse and in light of the overwhelming evidence of physical, sexual and emotional abuse then James would have been entitled to the following mandatory protections and safeguards established by New Mexico law through its Children's Code:

a. the filing in Children's Court of a timely petition alleging neglect or abuse or seeking custody and temporary placement in safe substitute care;

b. the appointment of an attorney to represent his legal rights in proceedings conducted in Children's Court;

c. the appointment of a Guardian ad Litem charged with the duty of zealously representing his best interests in proceedings conducted in Children's Court and other judicial proceedings;

d. the development of a proposed treatment plan that would have set forth steps to ensure that his physical, medical, psychological and educational needs were

met, that Krista's mental health needs were met, and that his best interests were served;

e. the appointment of a Court-appointed Special Advocate ("CASA") who would have assisted the court in determining his best interests by investigating the facts of the situation, submitting reports to the parties, and monitoring compliance with the treatment plan;

f. written notice of the factual grounds supporting any change in his placement, including a return to Krista's home, with copies sent to the children's Guardian ad Litem, attorney, CASA, and the court prior to the placement change going into effect, and the right to contest the proposed change;

g. an adjudicatory hearing to determine disposition of his placement and treatment, and the submission of a predisposional report that would have provided the court with pertinent information regarding his well-being;

h. the right to be heard in Children's Court at such a hearing;

and

i. a safe home environment provided by a substitute caregiver and supervised by monthly home visits from CYFD as well as supervision by the Guardian ad Litem and CASA.

NMSA 1978 §§32A-4-1 through 32A-4-34.

343. At all times materials to this lawsuit, James Dunklee Cruz had a fundamental right, protected by the First and Fourteenth Amendments to the United States Constitution, to petition and have access to the courts and to have his interests heard, to utilize the legal remedies and

procedures established by the State of New Mexico and to have due process in Court supervision over his care, custody and home environment for the purpose of assuring his health and safety.

344. At all times material to this lawsuit, Defendants Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10 had a statutory and regulatory obligation to ensure James' physical and emotional safety and well-being and to keep him safe in his living environment and otherwise control the safety standard of the environment.

345. The official actions taken by Defendants Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10 frustrated and prevented James' access to the Children's Court, and from assuring that his placement, including his placement with his biological parent, and any custody determination, was accomplished in a manner consistent with, and governed by, the requirements of the New Mexico Children's Code.

346. Because of the official actions of these Defendants, as set forth above, no action was filed in the Children's Court on James' behalf in conscious disregard for clear physical evidence of repeated abuse and neglect, a medical diagnosis of physical abuse, numerous and consistent disclosures by James about abuse he suffered and was continuing to suffer at the hand of his mother, her current roommates, her previous roommates or boyfriends, thirteen (13) total referrals from members of the community concerned about James' safety, and Krista's long track record of failing to comply with CYFD's directives.

347. Defendants acted knowingly, recklessly or with deliberate indifference toward and conscious disregard of the substantial, obvious and known risk of harm to James.

348. The conduct of these Defendants was knowing, unlawful, deliberate, indifferent, malicious, reckless, wanton, and conscience-shocking.

349. As a direct and proximate result of these Defendants' conduct as set forth above, James suffered horrifying physical abuse, traumatic emotional abuse, severe mental anguish, and ultimately death as a direct result of the deprivation of his constitutional rights.

COUNT II: CIVIL RIGHTS CLAIMS AGAINST CYFD, MELISSA GARCIA, MARVIN PAUL, MATTHEW HERNANDEZ, JESSICA ETOLL AND JOHN DOES 1-10 SPECIAL RELATIONSHIP & BREACH OF DUTY TO PROTECT FROM KNOWN DANGER

350. All previous allegations are incorporated by reference as if fully set forth herein.

351. CYFD and its investigators owe a duty of reasonable care in exercising the statutory authority to keep children safe from harm when it comes to specific allegations of abuse and neglect the agency receives.

352. When CYFD receives and screens in a report of child abuse or neglect the Children's Code provides that it *shall* take immediate steps to keep children for whom it receives a report of abuse or neglect safe. NMSA 1978 §32A-4-3 (C) (emphasis added).

353. The Children's Code further provides that at the completion of the investigation on a neglect or abuse report, the department *shall* either recommend or refuse to recommend the filing of a petition for ex parte custody of the child. NMSA 1978 §32A-4-4 (C) (emphasis added).

354. CYFD policy and procedure provide clear instruction to investigators and their supervisors regarding the thorough investigation of reports of abuse. See PR 8.10.2.8-PR 8.10.6.22 *implementing* 8.10.3 NMAC.

355. James was totally reliant on the actions of CYFD and Defendants Garcia, Etoll, Hernandez, Paul and John Does 1-10 to become a ward of the State and be protected from harm in a safe environment.

356. Each time CYFD imposed a Safety Plan and other verbal directives on Krista regarding James' care, it exercised its authority under the laws of New Mexico to make determinations about James' safety, physical condition, care and home environment and asserted custody and control over James' living conditions.

357. Each Safety Plan that Defendants Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10 created directed Krista to fulfill certain obligations *specifically in exchange* for declining to exercise CYFD's authority to take James into legal custody, stripping her control over the living arrangements, and significantly changing the nature of her custody.

358. These directives, which effectively placed James in environments within the State's control, included but are not limited to the following:

- to reside or not reside in certain environments including a clear directive not to reside with Pamela Esparza and Zerrick Marquez beginning in October 2019;
- to have access to or to not have access to James, including a clear directive to Krista and the October 2019 respite providers that CYFD designated and vetted for James not to allow James and Krista to have any contact;
- to agree to seek mental health and other services;
- to place James into daycare for his safety while she was at work;
- to attend multiple Imminent Risk of Removal Family Centered Meetings where it was clear that her continued right to parent James was at risk;
- dispatching police on multiple occasions to find James after the October 23, 2019 FCM and to investigate his welfare and/or remove him from Krista's legal custody;

- requiring Krista to allow CYFD to conduct multiple inspections of the various home environments where she kept James specifically to determine their safety from birth through the end of his life;
- causing law enforcement to forcibly enter Zerrick Marquez and Pamela Esparza's apartment on October 24, 2019 due to imminent risk of harm they posed to James' safety;
- requiring Krista to check in with investigators via phone calls and meetings;
- ordering Krista to seek counseling and other services;
- designating state-approved substitute caretakers to parent James instead of Krista including but not limited to Sandra Lowe, Krista's sister, Jessica (August 2015); Amber Lowe (June 2019), and the two respite providers from October 18, 2019-October 23, 2019;
- directing Amber Lowe to obtain a Power of Attorney to informally transfer Krista's parental rights to Ms. Lowe;
- directing Amber Lowe to contact law enforcement and/or CYFD if Krista came back to take James out of her substitute care;
- directing the October 2019 respite care providers to contact law enforcement and/or CYFD if Krista came to take James out of their substitute care;
- causing law enforcement to run background checks on the substitute caregivers CYFD designated in its safety plans, including but not limited to the October 2019 respite care providers.

359. The directives of each individual Safety Plan constituted a deprivation of liberty and an effective exercise of custody over James sufficient to trigger the State's affirmative duty to ensure his safety in his home environment.

360. These state-issued Safety Plans and unilateral verbal directives over Krista and James' home environment as well as CYFD's legal obligation to keep James safe after substantiating that he had been abused or neglected created a special relationship which imposed a corresponding duty to assume responsibility for James' safety and general well-being.

361. While in this functional custodial or special relationship with CYFD, Defendants Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10, James had a fundamental substantive due right, protected to by the Fourteenth Amendment, to a safe and proper home environment.

362. James further had a constitutional right to be safeguarded from the specific physical, emotional and sexual abuse which CYFD, Defendants Garcia, Paul, Hernandez and Etoll were each personally aware he was experiencing in his mother's care, which was ongoing and which Etoll predicted to Garcia and Paul would continue to occur after the October 23, 2019, FCM and Safety Plan.

363. Defendants Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10 had a duty to ensure the safe and proper disposition of young James, who was within their custody and control pursuant to these Safety Plans and open investigations, and to protect him from known abuse.

364. Defendants Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10 additionally had a continuing duty to ensure James' safety pursuant to the multiple investigations both regarding James and the separate investigations regarding Pamela Esparza and Zerrick Marquez's children. All of these investigations remained open at the time of James' death.

365. James was totally dependent on Defendants to meet his basic needs, particularly due to his young age.

366. It is the primary duty of a CYFD investigator and investigative supervisor to screen for current and future risk of harm to a child for whom they have substantiated abuse. The best predictor of future abuse is past abuse, and certainly current abuse of a child.

367. Melissa Garcia had personal knowledge of and consciously disregarded obvious and/or known risk to James. Ms. Garcia was aware of the multiple known injuries to James, both recent and healing, including head to toe bruises, scratches, and scars documented in photographs that had been presented to her. In addition, she consciously disregarded clear disclosures of abuse by James' mother and caregivers during both the Para Los Ninos SANE exam on October 21, 2019 and the All Faiths Safe House interview on October 23, 2019.

368. Ms. Garcia also consciously disregarded each of the multiple investigations, substantiated allegations of abuse, previous failed safety plans, and documentation of Krista's life long mental health issues and trauma, all of which was accessible to her in the CYFD data system, and which she had a duty to review as part of the investigations.

369. Melissa Garcia breached her duty to ensure a thorough investigation was completed before making a determination to cause an ex parte custody order to be requested for each of the referrals that she supervised from September through October 2019. This breach was a violation of law, regulation, policy and an abdication of her professional judgment.

370. Melissa Garcia's decision not to ask law enforcement to assist with a 48 hour hold and/or not to seek ex parte custody via CYFD's legal department on October 18, 2019, was a breach of her duty to James. This breach was a violation of law, regulation, policy and an abdication of her professional judgment.

371. Melissa Garcia additionally breached her duty to James when she directed that he be returned to Krista's care at the October 23, 2019, FCM. She knew that James had disclosed that very day and days prior during the Para Los Ninos exam that his mother was abusing him, her roommates were abusing him, her previous roommates/boyfriends had abused him and that Ms. Etoll, the assigned investigator, was adamantly recommending that they initiate immediate ex parte legal proceedings to keep James safe from further harm. Still, she failed her duty as County Office Manager to direct the legal division to initiate ex parte proceedings. This breach was a violation of law, regulation, policy and an abdication of her professional judgment and constitutes deliberate indifference to James' safety.

372. Melissa Garcia breached her duty to James when she failed to immediately initiate an ex parte custody petition and serve an Order for legal custody of James on Krista the moment she learned that Krista violated the October 23, 2019, Safety Plan by leaving the Joy Junction Homeless shelter and avoiding Etoll's calls. There is no requirement in the law that the child's location be known to CYFD prior to initiating the ex parte custody proceedings.

373. Each of Melissa Garcia's actions and inactions in violation of law and policy, and each abdication of her professional judgment was made with deliberate indifference to James' safety and put James at substantial risk of serious, immediate and proximate harm.

374. Melissa Garcia had personal knowledge of and consciously disregarded obvious and/or known risk to James. Ms. Garcia was aware of the multiple known injuries to James, both recent and healing, including head to toe bruises, scratches, and scars documented in photographs that had been presented to her. In addition, she consciously disregarded clear disclosures of abuse by James' mother and caregivers during both the Para Los Ninos SANE exam on October 21, 2019 and the All Faiths Safe House interview on October 23, 2019.

375. Melissa Garcia was aware of her breach in duty to James as evidenced by her decision to direct Jessica Etoll to locate James for the purpose of finally initiating the ex parte custody petition within twenty-four (24) hours after allowing him to return to Krista's care on October 23, 2019.

376. Marvin Paul also consciously disregarded each of the multiple investigations, substantiated allegations of abuse, previous failed safety plans, and documentation of Krista's lifelong mental health issues and trauma, all of which was accessible to him in the CYFD data system, and which he had a specific duty to review as part of the investigations.

377. Marvin Paul breached his duty to ensure a thorough investigation was completed before making a determination to cause an ex parte custody order to be requested for each of the referrals that she supervised from September through October 2019. This breach was a violation of law, regulation, policy and an abdication of his professional judgment.

378. Marvin Paul's decision not to ask law enforcement to assist with a 48 hour hold and/or not to seek ex parte custody via CYFD's legal department on October 18, 2019, was a breach of his duty to James. This breach was a violation of law, regulation, policy, and an abdication of his professional judgment.

379. Marvin Paul additionally breached his duty to James when he directed that he be returned to Krista's care at the October 23, 2019, FCM. He knew that James had disclosed that very day and days prior during the Para Los Ninos exam that his mother was abusing him, her roommates were abusing him, her previous roommates/boyfriends had abused him and that Ms. Etoll, the assigned investigator, was adamantly recommending that they initiate immediate ex parte legal proceedings to keep James safe from further harm. He failed his duty as Investigative Supervisor to direct the legal division to initiate ex parte custody proceedings. This breach was a violation of

law, regulation, policy and an abdication of his professional judgment and constitutes deliberate indifference to James' safety.

380. Each of Marvin Paul's actions and inactions in violation of law and/or policy, and each abdication of his professional judgment was done with deliberate indifference to James' safety and put James at substantial risk of serious, immediate and proximate harm.

381. Melissa Garcia and Marvin Paul were aware of the link between their breaches in duty to James and his brutal death at the hands of the abuser he named to them during two forensic interviews. Their awareness is evidenced by their immediate campaign to delete and change Etoll's investigation notes on or about December 11, 2019.

382. Marvin Paul's awareness of his breaches in duty to keep James safe is also evidenced by his text message to Tiffany Matteucci on December 12, 2019 in response to her statement that James should have been taken into custody at Duke City Urgent care and Mr. Paul responded "we all feel that way."

383. Mr. Paul additionally indicated his awareness of the breaches in duty when he indicated his awareness that litigation against CYFD was certain texting to Ms. Matteucci the day after James' death "you will be called as a witness."

384. Matthew Hernandez, an investigative supervisor who helped staff and oversee the Duke City Urgent care investigation, breached his duty to James when he failed to oversee a thorough investigation prior to determining that James should go into respite with a safety plan.

385. Matthew Hernandez breached his duty to James when he failed to direct Tiffany Matteucci to coordinate with law enforcement on site at Duke City to put James into a 48 hour hold for the purpose of initiating the ex parte custody process.

386. Matthew Hernandez breached his duty to James when he failed to ensure that Tiffany Matteucci enter accurate data and facts into the safety assessment tool, causing a seriously flawed and low risk assessment outcome.

387. Matthew Hernandez had personal knowledge of James' physical injuries and disclosures to Tiffany Matteucci on the night of October 18, 2019, and he consciously disregarded them in deliberate indifference to James' safety and well-being.

388. Defendants' conduct, as described herein, put James at substantial risk of serious, immediate and proximate harm. This risk was obvious and known to CYFD, Defendants Melissa Garcia, Marvin Paul, Matthew Hernandez Jessica Etoll and John Does 1-10 based on its numerous investigations from James' birth through his death as well as the volume of information the agency kept and controlled regarding Krista's own mental health diagnoses in her seven years in CYFD custody as a child as well as Sandra Lowe's history as an abuser.

389. Defendants acted knowingly, recklessly or with deliberate indifference toward and conscious disregard of the substantial risk of harm to James.

390. Each of the Defendants had personal knowledge of the risk of harm to James, and each of their breaches in duty to James is affirmatively linked to the injuries he suffered and to his brutal death at the hands of man they knew was abusing him.

391. Defendants Garcia and Paul were aware that their own abdications of professional judgment violated clearly established law, as evidenced first by the decision to send law enforcement to pick up James on October 24, 2019, within 24 hours of sending him back to Krista on the final Safety Plan, and by each of their actions in deleting the evidence of the history of their decision making leading up to James' death the week of December 11, 2019.

392. As a direct and proximate result of these Defendants' conduct as set forth above, James suffered horrifying physical abuse, traumatic emotional abuse, severe mental anguish, and ultimately death as a direct result of the deprivation of his constitutional rights.

COUNT III: CIVIL RIGHTS CLAIMS AGAINST CYFD, MELISSA GARCIA, MARVIN PAUL, MATTHEW HERNANDEZ, JESSICA ETOLL, AND JOHN DOES 1-10 DANGER CREATION

393. All previous allegations are incorporated by reference as if fully set forth herein.

394. James was known to Defendants as a member of a particularly vulnerable group of children pursuant to CYFD's own policies and risk assessment tool.

395. Krista's history of CYFD involvement herself; having James at 17 years old while she was still a foster child herself, the prior referrals for abuse or neglect regarding his older sibling, H.M. as well as the fact that Krista lost custody of H.M. in a civil proceeding all were indicators of risk to James per CYFD policy. In addition, any child under the age of five (5) years of age is considered to be more vulnerable for the purposes of CYFD risk assessment since they are dependent on an adult for their care and also because they are not yet school-aged and, therefore, not subject to the type of community supervision that acts as a safety net for so many abused and neglected children.

396. Perhaps most importantly, James was known to Defendants as a child with multiple referrals for abuse and neglect which began at birth and continued throughout his life. This fact alone, outside of the other factors, made him a member of an identified group of at-risk children pursuant to CYFD policy.

397. Defendants CYFD, Melissa Garcia, Marvin Paul, Matthew Hernandez, Jessica Etoll and John Does 1-10 affirmatively increased the danger of private violence to James by assuming informal custody of James in an unreviewable manner that ignored the clearly established

requirements of the children's code. This failure is directly linked to the increased violence James experienced over the four years of his life and between the first and final referrals of abuse and neglect made to CYFD as he never received the substantive or procedural due process protection he was entitled to receive.

398. The risk to James' safety was not only obvious it was known to Defendants; it was identified by investigators who substantiated allegations of abuse or neglect, it was identified in each of the four Safety Plans, and it was discussed at each of the at least three (3) Imminent Risk of Removal Family Centered Meetings. At the end of James' life, Defendant Etoll was clearly articulating the risk to Garcia, Paul and Hernandez. Defendants' ignorance of the risk was conscience-shocking.

399. Defendants Garcia, Paul, Etoll and Hernandez each had personal knowledge of overwhelming evidence of physical abuse and of James' specific naming of his abusers past and present: Krista, Pamela, Zerrick, Jesus and Arturo. Their ignorance of this evidence, of the medical diagnosis of physical abuse, and of James' own desperate plea during the Para Los Ninos SANE exam that "I dream about getting hit and I am not going to get hit again" shocks the conscience and shows deliberate indifference to James' health, safety and well-being.

400. Defendants CYFD Garcia, Paul, Etoll, Hernandez and John Does 1-10 knew or should have known about each of the thirteen (13) total referrals screened-in by CYFD and documented in its database. Each of these Defendants additionally knew or should have known about the long history of trauma and abuse between Krista and Sandra Lowe as well as Krista and her firstborn son, H.M. Each Defendant's disregard for this documented information, which clearly established law and policy required them to review and to consider in all risk-analysis and decision-making is conscience-shocking.

401. Defendants CYFD Melissa Garcia, Marvin Paul, Matthew Hernandez, Jessica Etoll and John Does 1-10, affirmatively increased the danger of private violence to James through each of the multiple Safety Plans, FCM's, phone calls and check ins to Krista, and verbal directives to Krista immediately followed by the repeated failure to enforce those directives. Krista, Arturo, Jesus, Zerrick and Pamela were each allowed unrestricted access to James and continued to abuse him as a direct result of each of the Defendants' individual and collective failures to enforce law and policy even in the face of confirmed, substantiated abuse. Each of these private actors understood that their violence, while on CYFD's radar from time to time, would ultimately go unchecked because it always had.

402. Each abdication of professional responsibility, each departure from the law and policy on thorough investigations, and each time Defendants allowed James to return to Krista's care in the midst of confirmed abuse, instead of initiating ex parte custody, the Defendants acted in conscious disregard to the objectively reasonable risk that he would be abused again.

403. This conscious disregard for James' health and safety continued throughout his life, with each of the thirteen screened-in community referrals and reached its peak in the fall of 2019.

404. As a result of Defendants' actions and inactions, James was subject to ongoing and increased violence after each and every referral that came in to CYFD, culminating in his brutal and violent death.

405. Defendants CYFD, Garcia, Paul, Hernandez, Etoll and John Does 1-10 ignored clearly established law and policy in failing to take immediate custody of James on October 18, 2019, and again at the October 23, 2019, FCM.

406. By orchestrating, directing, authorizing and approving James' placement in each home environment, pursuant to each Safety Plan and to verbal directives, including but not limited to the

October 18, 2019 and October 23, 2019 Safety Plans, Defendants CYFD, Melissa Garcia, Marvin Paul, Jessica Etoll and John Does 1-10 substantially departed from accepted professional judgment, practice or standards in a way that abdicated professional judgment and knowingly or recklessly subjected James to grave, immediate and obvious danger.

407. Defendants failed in their obligation to adhere to the requirements of the Children's Code and seek removal of James from Krista's legal custody on multiple occasions, bypassing established professional and legal procedure, substantially departing from accepted professional judgment, practice or standards in a way that abdicated professional judgment in the designation and determination of his home environment.

408. Defendants' failure to exercise the duty to properly investigate allegations of abuse and neglect, and to exercise professional judgment in the face of evidence of abuse violated James' Fourteenth Amendment right to be free from harm in each of the home environments over which CYFD exercised its authority and dominion.

409. Defendants acted knowingly, recklessly or with deliberate indifference toward and conscious disregard of the substantial risk of harm to James.

410. The conduct of these Defendants was unlawful, deliberate, indifferent, malicious, reckless, wanton, and conscience-shocking.

411. As a direct and proximate result of these Defendants' conduct as set forth above, James suffered a lifetime of horrifying physical abuse, traumatic emotional abuse, severe mental anguish, and ultimately death as a direct result of the deprivation of his constitutional rights.

WHEREFORE, Plaintiffs request this Court to enter judgment in their favor and against Defendants for the following:

1. Implementation of new policies, procedures and protocols regarding the training of employees in the investigations unit to address the repeated failures presented in this case;
2. Compensatory damages in an amount to be determined at trial;
3. Punitive damages in an amount sufficient to punish Defendants for their deliberately indifferent and reckless violations of James Dunklee Cruz's constitutional rights and to deter such violations in the future; and
4. Reasonable attorneys' fees and costs of suit under 42 U.S.C. § 1988
5. Pre- and post- judgment interest;
6. Cost incurred in prosecuting this action;
7. For any other relief deemed just and proper by this Court.

Respectfully submitted,

/s/ Rachel Berenson
Rachel Berenson
BERENSON & ASSOCIATES, P.C
415 Sixth Street NW
Albuquerque, NM 87102
(505) 243-4400 (Voice)
Rachel@nmjusticelaw.com

-and-

Sara S. Crecca
Sara S. Crecca
LAW FIRM OF ALEXANDER D. CRECCA, P.C.
3200 Monte Vista Blvd., NE
Albuquerque, NM 87106
(505) 385-6517
saracrecca@creccalaw.com

Alexander D. Crecca
Alexander D. Crecca
LAW FIRM OF ALEXANDER D. CRECCA, P.C.
3200 Monte Vista Blvd., NE
Albuquerque, NM 87106
(505) 766-9999
acrecca@creccalaw.com