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DX-3721

Case Number:
D-101-CV-2023-02838



Systemic Failures: How CYFD Endangers the Children It's Meant to Protect

APRIL 2026



Systemic Failures: How CYFD Endangers the Children It's Meant to Protect

Published by the New Mexico Department of Justice

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April 2026

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EXECUTIVE SUMMARY

New Mexico's child welfare system is in crisis. The New Mexico Department of Justice (NMDOJ) investigation into the Children, Youth and Families Department ("CYFD" or "Department") identified systemic failures that have repeatedly endangered the children CYFD is sworn to protect. These failures are not isolated—they are pervasive, deeply entrenched, and too often result in preventable harm.

State law is unequivocal: CYFD should strive to preserve and reunify abused and neglected children with their families whenever possible, but when that goal conflicts with a child's health and safety, *the child's interests must prevail*. The NMDOJ investigation makes one fact unmistakable: CYFD has completely inverted that legislative mandate and abandoned its core mission to protect children as its highest duty. Instead of safeguarding vulnerable children, the Department has prioritized family reunification at virtually any cost—returning children to dangerous caregivers with histories of substantiated abuse or chronic neglect, and who refuse treatment or services to address those underlying issues. This misalignment between mandate and practice has had devastating consequences, including the deaths of at least seven children since this investigation's inception. And this scale and severity of harm to children over the past year is not an anomaly. New Mexico has long faced disproportionately high levels of maltreatment, *repeat* maltreatment, and child fatalities compared to national averages.

Interviews, case reviews, and consultation with child welfare experts reveal a troubling pattern: CYFD selectively enforces its own rules—rigidly enforcing these rules when convenient, but disregarding or misinterpreting them when compliance requires decisive intervention to protect children. Policies and protocols are often wielded as shields against accountability, or disregarded altogether. When children are injured or killed, CYFD's instinct is not transparency, but self-preservation—deflecting blame, concealing poor decisions, and protecting its image instead of confronting mistakes and embracing lessons that could prevent future harm.

In addition to routinely delaying removals of children from dangerous environments and prematurely reunifying them with unfit caregivers, other systemic failures have emerged, including:

1. CYFD's leadership has lacked the qualifications and commitment necessary to uphold its obligations, fostering a culture of insularity and resistance to oversight. Rather than embracing accountability and reform, the Department has repeatedly deflected scrutiny, degraded internal guardrails, and misused confidentiality protections to obscure its failures.

2. CYFD has systematically de-professionalized its workforce, forgoing the hiring of licensed social workers and relying on staff that are ill-equipped to handle the complex demands of child welfare practice. Combined with crushing caseloads, inadequate training, and absent supervision, this approach fuels burnout and turnover.
3. Investigative practices are deeply flawed. CYFD investigators skip essential interviews, neglect mandatory home visits, apply safety and risk assessment tools inconsistently, and rely on hollow safety plans. These flaws are compounded by a misunderstanding of evidentiary standards, allowing obvious abuse and neglect to go unsubstantiated.
4. Permanency practices are wholly deficient, driven by chronic understaffing, lack of access to trauma-focused services, inaccurate court reports, hearing delays caused by employee unpreparedness, and case management breakdowns that jeopardize child well-being.
5. Failed implementation of the state's Comprehensive Addiction and Recovery Act (CARA) law leaves over 1,200 drug-affected newborns at risk each year. Untimely guidance, lack of training for medical providers, unenforceable plans of care, and poor oversight have led to repeated tragedies, including preventable deaths from narcotics exposure.
6. CYFD impedes criminal investigations and devalues the expertise of law enforcement. The Department ignores requests for protective holds or intervention, even amid escalating danger. As a result, children are returned to unsafe environments, leading to repeated police involvement. CYFD's actions delay or prevent forensic interviews and necessary medical exams, obstructing criminal investigations and prosecutions.
7. Foster families receive inadequate support, poor communication, and face retaliatory tactics, even as CYFD confronts a critical shortage of non-relative foster homes. These practices erode trust, increase turnover, and jeopardize outcomes for children in state custody.
8. Instability in the foster care system is worsening, with children experiencing placement moves at nearly twice the national average—with some enduring dozens of disruptive relocations. Beyond breaching legal mandates, the inability to ensure stable homes derails support systems, impairs formation of healthy attachments, and compounds trauma.

9. CYFD has heavily relied upon office buildings as makeshift placements for children in state custody, exposing them to physical injury, sexual assault, drug use, and severe psychological harm. Housing children in office buildings strips them of privacy, therapeutic care, and the stability of a family setting, while overwhelming staff who must manage chaotic conditions and balance a child's supervision with daily tasks.
10. CYFD's excessive dependence on congregate care facilities—designed only for short-term clinical placements—has led to unsafe conditions characterized by violence, misuse of restraints, staff mistreatment, chronic understaffing, lack of supervision, and even suicide.

The stories and data in this report are not hypothetical—they are the lived histories of real children, some still dependent on CYFD's actions, and others whose lives were irreversibly shaped or cut short by the Department's decisions. The child welfare crisis is not an unavoidable reality, but the direct result of poor leadership, indefensible choices, missed interventions, and a widespread lack of transparency. CYFD's shortcomings go beyond mere bureaucratic mismanagement—they represent a systematic moral failing—measured in children continuing to be abused, neglected, and lost.

The NMDOJ's investigation was not intended to merely catalog CYFD's many missteps, but rather serve as an urgent call to action for policymakers, stakeholders, the newly appointed child advocate, and leaders within CYFD. The Department's history of empty assurances and half-measures in safeguarding children are no longer acceptable—the price for delay and denial has been too high. The path for CYFD to restore public trust is clear: acknowledge the depth and impact of their failures, institutionalize accountability, and embrace meaningful, lasting change. CYFD's future legitimacy—and the safety and well-being of those it serves—depends on a renewed and unwavering commitment to its highest duty: putting children first.

A digital version of this report is available at <https://nmdoj.gov/publications/cyfd-report>.

A Note About Confidentiality Measures and CYFD's Lack of Cooperation

The NMDOJ has sought to fully protect the privacy of the children and families highlighted in its investigation. This report utilizes pseudonyms in place of actual names and initials and performs targeted redactions as necessary. Although pseudonyms are used, each case study described in this report is grounded in the real experiences of children and caregivers who have been involved with CYFD. While some factual scenarios may be clearly recognizable from prior public reporting, pseudonyms are applied uniformly throughout for consistency. The NMDOJ has complied with all statutory requirements for safeguarding sensitive information, consistent with the underlying purpose of confidentiality provisions set forth in the Children's Code. At the same time, the NMDOJ has sought to provide the public with the fullest possible account of its investigative findings.

Furthermore, multiple witnesses who spoke with the NMDOJ anticipated retaliation by CYFD for their participation. Former CYFD employees shared well-founded concerns that providing accurate information regarding CYFD's practices would lead to the loss of future employment prospects in the child welfare field. Similarly, multiple foster parents expressed a fear of an abrupt and unjustified removal of children in their care should they share an unvarnished account of their experiences with CYFD. In order to counteract the chilling effect that this fear of retaliation has on these individuals, this report withholds their identities if so requested.

The NMDOJ's measured, transparent approach stands in stark contrast to [CYFD's lack of cooperation with the NMDOJ](#) throughout this investigation. Although CYFD initially provided relevant records, its assistance abruptly ceased following the replacement of its former general counsel and the Attorney General's announcement of the NMDOJ investigation in April 2025. Over the next six months, the [NMDOJ made more than ten \(10\) formal requests for child abuse and neglect records](#) essential to its inquiry. CYFD's current general counsel and public records custodian consistently resisted these lawful requests. CYFD's approach was consistent: deflect, delay, and withhold. As a result, to advance its inquiry, the NMDOJ was forced to piece together critical evidence from a patchwork of alternative sources. When CYFD did finally produce records, the disclosures were so limited and untimely that they held little investigative value. As an example of one of the many emails sent by the NMDOJ to CYFD seeking relevant records:

From: Sean Sullivan <SSullivan@nmdoj.gov>
Sent: Monday, August 25, 2025 8:00 AM
To: Romero, Amanda, CYFD <Amanda.Romero@cyfd.nm.gov>
Cc: Martinez, Alicia C, CYFD <AliciaC.Martinez@cyfd.nm.gov>; Cassel, William, CYFD <william.cassel@cyfd.nm.gov>; Dennis Park <DPark@nmdoj.gov>; Jonathon Talley <JTalley@nmdoj.gov>; Nick Nuñez <NNunez@nmdoj.gov>
Subject: [EXTERNAL] Re: New Mexico Department of Justice Law Enforcement Records Request

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

Good morning -

I am following up on the NMDOJ's letter of August 13, 2025. To date, no response has been received by CYFD. This email services as the **10th lawful request for materials under the New Mexico Department of Justice's capacity as a law enforcement entity, exempt from confidentiality under Section 32A-4-33(G)(7)**. We are supremely disappointed in CYFD's obstruction of our investigation to this point, and hope that the posture of the Department changes in the near future.

I again make myself available for a conversation as to what it is that the NMDOJ is seeking.
Sean



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Moreover, throughout the NMDOJ's investigation, CYFD routinely invoked an inappropriately broad reading of the Children's Code confidentiality statute to avoid disclosure of pertinent information, ostensibly under the guise of protecting the identity of parties involved in abuse and neglect proceedings. In effect, CYFD's application of confidentiality operates more as an impediment to transparency and accountability than as a genuine safeguard for the privacy of children and families.

Whether due to an indefensibly expansive interpretation of confidentiality laws or a motivation to restrict access to materials that may result in public scrutiny, the result is the same: CYFD has obstructed the NMDOJ's investigation. This institutional defiance has occurred despite Governor Lujan Grisham's public commitment to cooperate with the Attorney General's inquiry:

“As the State’s attorney, [AG] Torrez has authority to investigate CYFD or any other state agency, and the [G]overnor’s administration always cooperates and shares any information requested.”¹

CYFD has not upheld that commitment. In refusing to respond to the state’s chief law enforcement agency, CYFD invites the question of what confidence the public can have in the Department to be accountable to the children, families, and communities it serves.

¹ Marilyn Upchurch, [New Mexico Attorney General launches investigation into CYFD](#), KRQE (April 22, 2025).

CONTENT WARNING

This report addresses sensitive topics, including abuse, neglect, and fatalities of children, as well as references to physical and sexual violence, substance abuse, and suicide. Reader discretion is advised.

I. INTRODUCTION

“This haunts me . . . CYFD dropped the ball and a child died, and it’s not okay.”

These words, spoken under oath by a former CYFD abuse and neglect investigator, describe the case of Leo M.—a young child who was rushed to an Albuquerque hospital with catastrophic injuries: multiple facial and scalp contusions; lacerations to his lungs, liver, and pancreas; rib and skull fractures; and brain hemorrhages. He died that day, one month shy of his fifth birthday.

CYFD ignored immediately apparent warning signs and twelve credible reports of abuse and neglect, leaving Leo in severe danger. Despite overwhelming evidence of risk, the Department relied on ineffective safety plans, closed investigations prematurely, repeatedly chose inaction over intervention, and prioritized reputational protection over accountability. These failures enabled ongoing harm that ultimately led to Leo’s preventable death. This report exposes a devastating pattern of similar failures and their fatal consequences.

CYFD is New Mexico’s primary child protection agency, entrusted with preventing and responding to child abuse and neglect; providing a safe and stable foster care system; and upholding every child’s right to grow up in security and dignity. This mission is not aspirational—it is mandated by state law, federal requirements, and court-monitored reforms, all designed to ensure that CYFD prioritizes the health and safety of children above all else. The NMDOJ initiated its investigation because CYFD has failed in that mission.

The NMDOJ’s investigation drew upon a wide array of sources: over 20,000 pages of relevant case files, court records, federal and state evaluations, internal child welfare data, and legislative oversight materials. The investigative team interviewed recent CYFD employees, including those in leadership positions; foster parents; youth attorneys and guardians ad litem; child abuse prosecutors; law enforcement officials; neonatal intensive care (NICU) nurses, managed care organization care coordinators, residential treatment center practitioners, child psychiatrists, and other medical professionals; professors of social work; legislators and Legislative Finance Committee (LFC) staff; court-appointed special advocates; children who have aged out of foster care; and families impacted by New Mexico’s child welfare system. The NMDOJ also sought the expertise of two independent child welfare specialists, and consulted key advocacy organizations and community stakeholders.

This report begins by discussing the legal standards and practical framework underpinning CYFD’s statutory obligations. It then offers a detailed examination of eight core

systemic failures that repeatedly surfaced throughout the investigation. Findings are anchored by case studies that illustrate the human consequences of CYFD's breakdowns, as well as expert reviews that assess the Department's performance against best practices and national standards. The report concludes with targeted, stakeholder-driven recommendations, which outline ways to build a skilled, supported workforce; strengthen abuse and neglect investigations; ensure rigorous safety assessments and safety planning; advance child-centered permanency practices; and embed transparency into CYFD operations.²

To ensure transparency and allow the public to independently assess the NMDOJ's findings, this report provides direct access to hundreds of original source documents, law enforcement body camera videos, and recorded interviews. The report narrative is accompanied by excerpts from CYFD case files, court records, police reports, and medical documents. These materials enable readers to verify the information firsthand, and better understand the far-reaching impact of CYFD's failures on the children, families, and communities forced to bear the consequences.

² This report also includes appendices with commonly used abbreviations and acronyms, and a list of figures and tables.

II. BACKGROUND & LEGAL FRAMEWORK

This section establishes the legal and procedural framework within which CYFD operates—the statutes, regulations, and policies and define its obligations to children and families, and the step-by-step process through which the Department investigates abuse and neglect and plans for a child’s permanency.

A. CYFD’s Mandate in Child Welfare

CYFD is responsible for protecting and supporting the well-being of children, youth, and families across New Mexico.³ The Department’s mission is carried out through various divisions, including:

- Protective Services Division—Investigates reports of child abuse and neglect, manages the state’s foster care system, and facilitates adoptions.
- Behavioral Health Division—Coordinates state behavioral health policy for children, provides clinical consultation, and oversees facility licensing and certification.
- Family Services Division—Connects with and provides direct services to families.
- Juvenile Justice Division—Focuses on prevention and early intervention for youth at risk of delinquency.⁴

CYFD is tasked with upholding and applying the Children’s Code⁵ in accordance with the legislature’s intent. The New Mexico Legislature has mandated that the Children’s Code be interpreted in a way that advances several public policy objectives—most crucial among them:

“[T]o provide for the care, protection and wholesome mental and physical development of children coming within the provisions of the Children’s Code **and then** to preserve the unity of the family whenever possible. **A child’s health and safety shall be the paramount concern.**”⁶

CYFD’s Protective Services Division (PSD) is obligated to protect children from abuse and neglect—and only when safely possible—to preserve the integrity of the family unit.⁷ CYFD has divided its protective services division into three units: (1) Investigations; (2) Permanency Planning; and (3) Placements. These three units (called “pillars”) work together

³ CYFD and its respective divisions were established by statute in 1992. See NMSA 1978, § 9-2A-4 (1992, as amended through 2005).

⁴ New Mexico Children, Youth & Families Department (CYFD), <https://www.cyfd.nm.gov>, (last visited Feb. 3, 2026).

⁵ See NMSA 1978, Chapter 32A.

⁶ NMSA 1978, § 32A-1-3(A) (emphasis added).

⁷ *Id.*; see also 8.8.2.12 NMAC (“PSD shall make reasonable efforts to protect reported children from abuse and neglect, and when safely possible, to preserve the integrity of the family unit.”).

to investigate child abuse and neglect and secure a permanent and safe placement for children who have experienced maltreatment at the hands of their caregivers.

B. CYFD’s Investigations & Permanency Planning Process

Step 1 - CYFD investigates reports of abuse and neglect

When child abuse or neglect is suspected, a report is made to CYFD’s Statewide Central Intake (SCI) hotline or directly to law enforcement. All adults in the state are mandatory reporters if they know or have reasonable suspicion to believe a child has been abused or neglected.⁸ The Children’s Code defines a “neglected child” as a child who: (1) has been abandoned by their parent, guardian, or custodian; (2) lacks proper parental care and necessary well-being due to faults or refusal of the parent, guardian, or custodian; or (3) has been physically or sexually abused with the parent, guardian, or custodian failing to protect them.⁹ Physical abuse includes those instances where a “child suffers from strangulation or suffocation...or in which the child exhibits skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling or death...”¹⁰ For child abuse to be substantiated, the child’s injury or death must lack a justifiable explanation, have an inconsistent explanation with the severity or nature of the condition, or have occurred under circumstances suggesting the injury was not accidental.¹¹

Once a report is received, SCI screens the information to determine whether it meets statutory definitions of abuse or neglect. If the report is “screened in”¹² for investigation, it is given a priority level that determines how quickly an investigator¹³ must see the child—Emergency (within three hours), Priority 1 (within 24 hours), or Priority 2 (within five days).¹⁴ The report is then forwarded to CYFD’s investigations unit for assignment. An investigation supervisor conducts a pre-initiation staffing with the assigned investigator to review the allegations, evaluate past protective services history, identify safety risks, and structure the

⁸ NMSA 1978, § 32A-4-3(A).

⁹ NMSA 1978, § 32A-4-2(G).

¹⁰ NMSA 1978, § 32A-4-2(I).

¹¹ Id.

¹² CYFD may “screen out” reports and decline to investigate for several reasons, including: non-specific allegations; insufficient information to locate the child; abuse or neglect that is “not current;” and/or the perpetrator is not a parent or guardian. 8.10.5.10(A)(f) NMAC. If CYFD has knowledge or reasonable suspicion that a child in their facility or custody is being abused or neglected, the agency is required to cross-report to law enforcement. NMSA 1978, § 32-4-3.

¹³ CYFD, [*Protective Serv. Invest. Procedures*](#) (8.10.3 NMAC) PR 8, § 4(3) (2024) (hereinafter “CYFD Invest. Proc.”). CYFD refers to those conducting abuse or neglect investigations as “investigation workers,” but this term will be shortened as “investigator” throughout for consistency and brevity.

¹⁴ 8.10.3.9(B) NMAC; CYFD Invest. Proc. PR 9, § 7.1 (“Time Frames for Initiation”).

investigation.¹⁵ For families with more than two prior abuse and neglect referrals, CYFD must conduct a higher-level supervisory review at the outset of the case.¹⁶

The investigation formally begins when the investigator makes face-to-face contact with the child. The investigator also interviews caregivers, other household members, and collateral contacts.¹⁷ The investigator must also conduct a home visit to observe the child's living environment.¹⁸

During the course of an investigation, the investigator must complete a safety and risk assessment using the Department's structured decision-making tools.¹⁹ The purpose of a safety assessment is to evaluate whether the child is likely to be in imminent danger of serious harm or maltreatment that requires a protective intervention. The safety assessment requires the CYFD investigator to input information learned during the investigation into a computer-generated program, which identifies whether there are "danger indicators"²⁰ present and whether the caregiver²¹ possesses the protective capacities necessary to ensure the child's safety.

Based on the investigator's analysis of the safety assessment, the child may be deemed: (1) safe; (2) safe with a plan; or (3) unsafe.²² When a child is determined to be "safe with a plan," the child may remain in the home with a safety plan,²³ which is designed to be a written set of actions the family must take to control the danger indicators identified during the safety assessment.²⁴ If a child is deemed unsafe, immediate placement outside the home is required to prevent further harm. Removal of a child may occur at any time during

¹⁵ 8.10.3.9 NMAC.

¹⁶ 8.10.3.18 NMAC; CYFD Invest. Proc. PR 18, § 5 ("Families with More Than Two Investigations").

¹⁷ 8.10.3.7(J) NMAC defines "collateral contact" as "any person who may be able to provide information to the protective services worker during an investigation of alleged abuse or neglect[.]"

¹⁸ 8.10.3.10(E) NMAC; CYFD Invest. Proc. PR 10, § 8.3 ("Home Visit").

¹⁹ 8.10.3.10(F) NMAC.

²⁰ 8.10.3.10(C) NMAC. Danger indicators may include prior abuse or neglect, substance abuse, domestic violence, and mental health issues. See also CYFD Invest. Proc. PR 10, § 8.1 (listing ten danger indicators); 8.10.2.7 NMAC (defining "danger indicators" as "conditions resulting in a child being exposed to harm or injury and was placed at risk of harm or injury that could occur immediately").

²¹ The term "parent" and "caregiver" are used interchangeably throughout this report. Those terms are intended to encompass guardians, legal custodians, and other adults who have primary responsibility for the care, supervision, and well-being of a child.

²² CYFD, *Safety Assessment Policy & Procedures Manual* 7–8 (2018) (hereinafter "CYFD Safety Manual"); see also 8.10.3.10 NMAC; CYFD Invest. Proc. § PR 10, 9.5 ("Safety Decision").

²³ A safety plan is a short-term plan of action to control dangers that is made when the safety assessment shows that one or more danger indicators is present and both the family and CYFD believe the child(ren) can safely remain in the home with the plan. A safety plan generally lasts for up to 21 days but may be extended for up to 42 days. CYFD Invest. Proc. PR 10, § 10.1 ("Safety Plans").

²⁴ *Id.* If an investigation reaches 42 days and the safety plan has not mitigated the danger indicators, a Family Centered Meeting (FCM) takes place, followed by consultation with CYFD's legal unit to decide if filing a petition for custody is appropriate.

the investigation when the investigator, in consultation with supervisors, concludes the circumstances surrounding the abuse or neglect pose an imminent danger to the child.²⁵

In addition to the safety assessment, and no later than 30 days from the first face-to-face contact with the child, an investigator must also complete a risk assessment. The risk assessment classifies families into low, moderate, or high-risk groups based on their overall probability of experiencing future protective services involvement.²⁶ Investigators use a “service matrix” to determine appropriate service referrals based on each investigation’s safety and risk profile.²⁷

CYFD is required to make a final investigation disposition within 45 days of accepting the abuse and neglect report.²⁸ The investigation disposition is arrived at after collaboration between the investigator and their supervisor, and states whether the child abuse or neglect report is substantiated or unsubstantiated. A substantiated finding means credible evidence exists to support the conclusion that the child has been abused or neglected. Credible evidence can include a parent’s admission, physical evidence, collateral witness statements, child disclosures, or the investigators’ observation.²⁹ The proof required to satisfy “credible evidence” is significantly lower than the proof required in criminal and civil court proceedings. An unsubstantiated finding means the information collected during the investigation does not support a finding that a child was abused or neglected. Throughout the investigation, the safety of the child should be the overriding concern for CYFD.³⁰ Safety and risk assessment determinations, interview responses, home visit notes, and investigation dispositions are documented in CYFD’s case management system: the Family Automated Client Tracking System (FACTS).

²⁵ 8.10.3.16 NMAC; CYFD Invest. Proc. PR 16, § 5 (“Seeking or Accepting Custody of Children, Including Indian Children”).

²⁶ 8.10.3.10 NMAC; CYFD Invest. Proc. PR 10, § 11 (“Risk Assessment”).

²⁷ 8.10.3.18–19 NMAC; CYFD Invest. Proc. PR 19, §§ 5–7.

²⁸ 8.10.3.19(A) NMAC.

²⁹ 8.10.3.17 NMAC; CYFD Invest. Proc. § 5 (“Investigation Decision”).

³⁰ NMSA 1978, § 32A-1-3 (explaining that the purpose of the Children’s Code is to “first to provide for the care, protection and wholesome mental and physical development of children . . . and then to preserve the unity of the family whenever possible.”); 8.10.3.10(A) NMAC (The safety of the child is the overriding concern throughout the casework relationship with the family. If the safety of the child is ever in conflict with the preservation of a family unit, the child’s need for protection always takes precedence.”); see also CYFD Invest. Proc. PR 10, § 5 (“Overarching Principles”).

When a child is alleged to have suffered abuse or neglect, CYFD must determine whether to seek legal custody.³¹ CYFD pursues custody by filing a petition in Children’s Court that sets out facts demonstrating the abuse or neglect, and the need for removal from parental care.³² If CYFD decides to seek custody of the child, it must ordinarily file its petition within three days; otherwise, the child must be returned to their parents.³³ Independent of this process, law

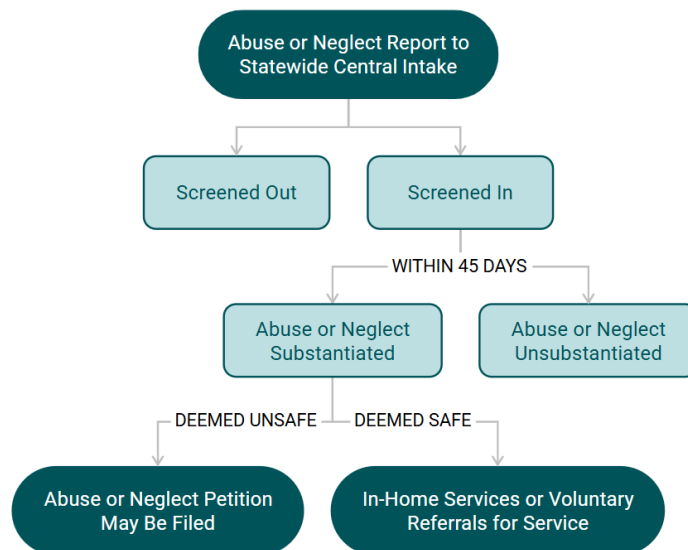


Figure 1. CYFD's abuse and neglect investigations process. Created by NMDOJ.

enforcement may take a child into custody without a court order if there are reasonable grounds of abuse or neglect and an immediate threat to the child’s safety.³⁴

Step 2 – The Children’s Court determines custody and permanency plans for the abused or neglected child

At the beginning of an abuse or neglect proceeding, separate attorneys are appointed for the parent and the child.³⁵ Within 10 days of CYFD filing a petition, the court must hold a “temporary custody hearing” to determine if the child should remain in state custody pending adjudication of the petition.³⁶

The court thereafter holds an “adjudicatory hearing” within 60 days of service of the petition to determine whether the child has been abused and/or neglected.³⁷ If the court determines that the child has been abused and/or neglected, it then proceeds to a

³¹ NMSA 1978, §§ 32A-4-4(E).

³² Children’s Court is a division of local New Mexico state courts specifically designated to address child and family legal issues. See NMSA 1978, §§ 32A-1-5 to -22.

³³ NMSA 1978, § 32A-4-4(E).

³⁴ NMSA 1978, § 32A-4-6(A)(1). This is often referred to as a “72-hour hold.” A prior version of this statute permitted law enforcement to take a child into temporary custody without filing a petition for up to two days, a so-called “48-hour hold.”

³⁵ NMSA 1978, § 32A-4-10. Under the statute, the court must appoint a guardian ad litem (GAL) to represent children under the age of 14. Section 32-4-10(C). A youth attorney is appointed to represent children age 14 or older. *Id.* The child’s attorney represents only the child’s best interest, and does not advocate for the parent or CYFD. Parents may hire their own attorney(s) if desired.

³⁶ NMSA 1978, § 32A-4-18(A).

³⁷ NMSA 1978, § 32A-4-19(A), -20(G)-(H).

“dispositional hearing,” which may be held in conjunction with—but no later than 30 days after—the conclusion of the adjudicatory hearing.³⁸ The court’s dispositional judgment may: (1) permit the child to remain with their parent subject to court-imposed conditions; (2) place the child under the protective supervision of CYFD; or (3) transfer the legal custody of the child to a noncustodial parent or CYFD.³⁹ When the court places a child in the legal custody of CYFD, the PSD is responsible for placing the child in the least restrictive setting consistent with their individual needs.⁴⁰ Placements may include relative or non-relative foster care; treatment foster care; or a licensed residential treatment center, group home, community home, or shelter.⁴¹ CYFD is required to make active efforts to place an Indian child in accordance with placement preferences under the Indian Child Welfare Act (ICWA).⁴²

When CYFD is granted custody of the child, a CYFD permanency planning worker (PPW) is assigned to oversee a set of goal-directed activities to help the child establish healthy and positive lifetime relationships.⁴³ The PPW establishes a “permanency plan” based on the PSD’s assessment of the child’s safety, permanency and well-being needs, vulnerability to his or her home life, and the protective capacities demonstrated by the child’s parents.⁴⁴ The two most common permanency plans are:

- a. *Reunification*, which aims to safely return the child to their parent’s custody. Reunification is typically pursued prior to other permanency plans⁴⁵ unless one of four “aggravated circumstances” exist.⁴⁶
- b. *Adoption*, which is considered when efforts to reunite the child with the parent have been unsuccessful or when reunification is otherwise not in the best interest of the child’s safety and well-being.⁴⁷

³⁸ 8.10.8.14 NMAC (“Adjudication and Disposition”).

³⁹ NMSA 1978, § 32A-4-22.

⁴⁰ 8.10.8.10(E) NMAC; CYFD, [Permanency Planning and Procedures](#) (8.10.8 NMAC) (2024), PR 10, § 13 (hereinafter “CYFD Planning Proc.”).

⁴¹ 8.10.8.10(C) NMAC; CYFD Planning Proc. PR 10, § 8.1.

⁴² 8.10.8.10(D) NMAC; CYFD Planning Proc. PR 11, § 5.

⁴³ 8.10.8.7(R) NMAC; CYFD Planning Proc. PR 8, § 4 and 5. CYFD refers to those performing permanency planning services as “permanency planning workers.” This term will be shortened as “PPW” throughout for consistency and brevity.

⁴⁴ 8.10.8.13 NMAC; CYFD Planning Proc. PR 9, §§ 5–8.

⁴⁵ 8.10.8.12(A) NMAC; CYFD Planning Proc. PR 13, § 5.1 (“Reunification”).

⁴⁶ NMSA 1978, § 32A-4-2(C). Aggravated circumstances exist where a parent has attempted, conspired to cause, or caused: (1) great bodily harm to the child or death to the child’s sibling; (2) great bodily harm or death to another parent; (3) the child to be subjected to torture, chronic abuse, or sexual abuse; or (4) when the parent had parental rights over a sibling terminated involuntarily.

⁴⁷ 8.10.8.12(B) NMAC; CYFD Planning Proc. PR 13, § 5.2 (“Adoption”).

Less frequent plans include guardianship, “placement with a fit and willing relative,” and planned permanent living arrangements (PPLA) for youth over age 16.⁴⁸

In conjunction with the permanency plan and to mitigate existing safety threats, CYFD develops a “case plan” that identifies the ongoing services needed by the child and parent. A case plan may include: (1) an ongoing evaluation of the child’s placement; (2) assessment of the child’s medical, behavioral, and educational needs; (3) identification of the parents’ needs to strengthen their protective capacities; and (4) visitation schedules.⁴⁹

Within 60 days after the dispositional hearing, the court holds an initial judicial review, during which CYFD informs the court of any progress made toward the permanency plan.⁵⁰ Thereafter, an initial permanency hearing must occur within six months of the initial judicial review or within 12 months of the child entering foster care, whichever occurs first.⁵¹ At the hearing, CYFD’s PPW presents the court with a report that outlines efforts made to return the child to their parents.⁵² The court continues to be involved, holding a permanency review hearing every six months while the child remains in CYFD’s legal custody.⁵³ The court will review the safety of the child, the appropriateness of the placement, the extent of the parent’s compliance with the case plan, and any progress made toward alleviating the causes necessitating placement in foster care.

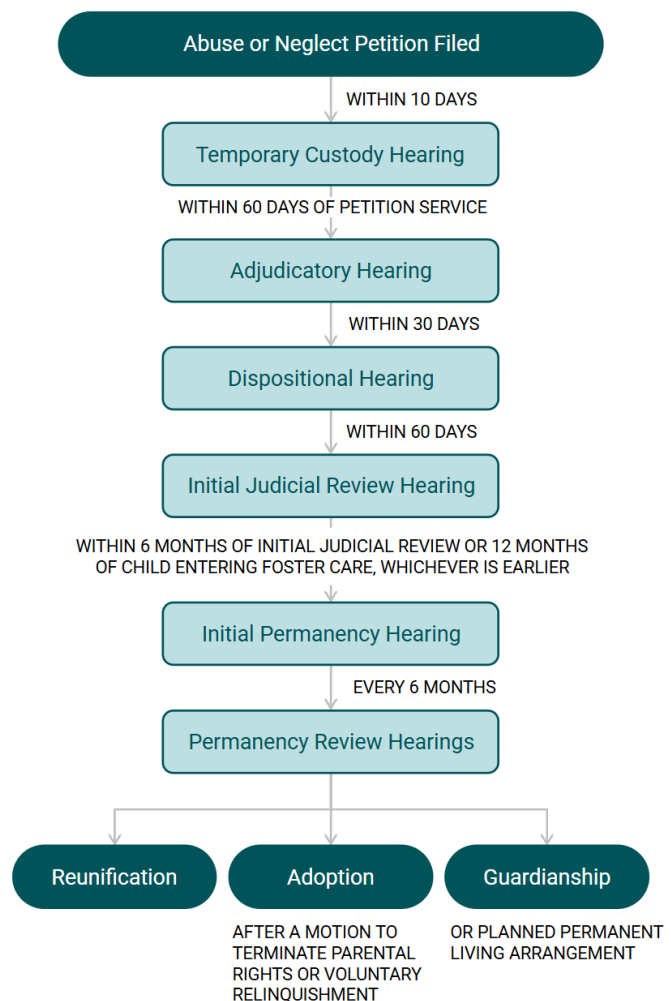


Figure 2. Key steps and deadlines in abuse and neglect legal proceedings. Created by NMDOJ.

⁴⁸ 8.10.8.12(C)-(E) NMAC; CYFD Planning Proc. PR 13, §§ 5.3–5.5.

⁴⁹ 8.10.8.7(B), 8.10.8.13(B) NMAC; CYFD Planning Proc. PR 12, § 7 (“Case Plan”).

⁵⁰ 8.10.8.15(A) NMAC.

⁵¹ NMSA 1978, § 32A-4-25.1(A); 8.10.8.15(B) NMAC.

⁵² 8.10.8.15(D) NMAC.

⁵³ 8.10.8.15(E) NMAC.

If the parents meet case plan requirements, mitigate danger indicators, and demonstrate protective capacities, the child may return home. If not, the court may terminate parental rights⁵⁴ to allow for the child's adoption or authorize CYFD to pursue an alternative permanency plan.⁵⁵

⁵⁴ NMSA 1978, § 32A-4-28(B) (stating that courts "*shall* terminate parental rights" where certain criteria are met (emphasis added)).

⁵⁵ 8.10.8.16 NMAC. CYFD's custody of a child terminates when: (1) the court dismisses or terminates CYFD's custody and returns the child to the parent or the child is adopted or otherwise placed in a PPLA; (2) a voluntary placement agreement expires; (3) court ordered custody expires; (4) the child reaches 18; or (5) a child in CYFD custody marries or joins the armed forces.

III. EIGHT SYSTEMIC FAILURES

Following a comprehensive investigation, the NMDOJ identified eight systemic failures in CYFD's execution of its child welfare mandate. These findings underscore critical weaknesses in CYFD's ability to safeguard New Mexico's most vulnerable children. This report is structured around these eight core failures, each illustrated—where possible—through relevant case studies.

A. Systemic Failure: Leadership Deficiencies, Workforce Instability & Operational Breakdowns

The challenges facing CYFD are not the result of minor organizational missteps or isolated poor decisions—they are deeply rooted in ineffectual leadership, workforce instability, and persistent operational breakdowns. CYFD's leadership operates in a vacuum—disconnected from their child protection mandate, dismissive of frontline staff, and often entrenched in a culture of retaliation. CYFD's leadership flaws have directly contributed to unsafe investigative practices and delayed or inappropriate permanency outcomes for children. The following sections examine the failures that have allowed these harms to continue—and worsen—despite repeated warnings and oversight efforts: (1) weak leadership and accountability avoidance; (2) acute social worker shortage; (3) barriers to employee retention; (4) chronic inadequacies in abuse and neglect investigations; and (5) delays and dangers in permanency planning.

1. Weak leadership and accountability avoidance.

Unqualified executive leadership, cultural resistance to oversight, and a long-standing failure to implement the *Kevin S.* settlement⁵⁶ have undermined CYFD's effectiveness.

⁵⁶ See Settlement Agreement, *Kevin S., et al. v. Blalock, et al.*, No. 1:18-cv-00896 (D.N.M. Mar. 26, 2020) ("*Kevin S. Settlement Agreement*").

a. *Executive leadership has lacked the qualifications and commitment necessary to uphold CYFD’s child protection mandate.*

Multiple former senior CYFD officials that spoke with the NMDNJ reported that Secretary Teresa Casados’ limited understanding of child welfare issues negatively impacted the Department’s performance. Though experienced in state and county government administration—and politically connected—none of her prior roles or connections adequately prepared her for the complex demands of leading a child protection agency. Lacking expertise in social work or a related field, her shortcomings were inevitable, and her tenure left CYFD directionless at a critical juncture. The individual leading a government department as vital as CYFD simply ought to possess relevant experience in child welfare. It defies reason to require professional experience of the state’s child advocate⁵⁷ while allowing the leader of the department it oversees to serve without comparable qualifications.

Given the breadth of CYFD’s responsibilities—spanning child protection, juvenile justice, and behavioral health—it is unsurprising that no secretary has brought expertise across all domains. This complexity has prompted former staff to question whether the Department’s structure is sustainable. Several have suggested that CYFD should be restructured to focus solely on child protective services, enabling more targeted leadership and operational focus. States like Arizona have adopted this approach by dividing responsibilities between separate departments—a Department of Child Safety and a Department of Juvenile Corrections.

No matter the Department’s structure, however, it is essential that CYFD leadership demonstrate both the capacity and commitment to understanding and removing the barriers that hinder frontline staff. One former PPW described a communication gap between CYFD

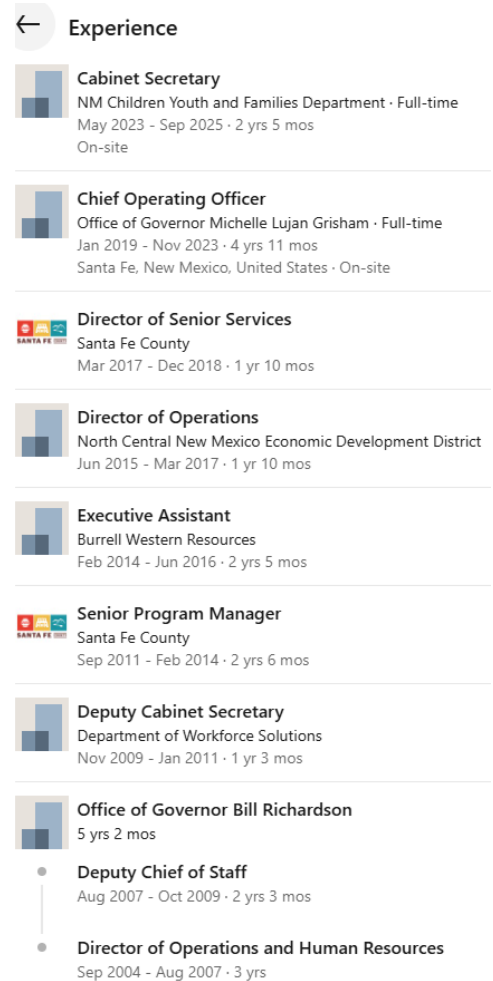


Figure 3. Teresa Casados' job history from LinkedIn (February 28, 2026).

⁵⁷ See NMSA 1978, § 32A-30-4 (“[T]he state child advocate shall have . . . five years of professional experience working in child protective or juvenile justice and be licensed in good standing as an attorney, a psychologist, or social worker”).

leadership and employees, characterizing the culture as one in which “everything is kept a secret” and where “there was no direction, only finger-pointing from upper management.” The PPW stated that her supervisor, the associate deputy director of permanency, often issued conflicting and confusing instructions without providing proper administrative support—a pattern that the PPW reported compromised child safety on many occasions. A former CYFD permanency director reported that leadership frequently micromanaged initiatives, and required the use of forms that were disconnected with field operations and lacked practical relevance.

According to mid-level managers, Secretary Casados often treated staff disrespectfully and allowed personal grievances to influence her decisions. One former director recounted being moved to a closet-sized office after raising concerns about one of Casados’ directives. Several employees expressed that the lack of support from CYFD leadership was especially disheartening given Secretary Casados’ pattern of hiring or promoting friends and family to key positions. Several individuals with personal ties to Secretary Casados that were hired or promoted within CYFD include:

- Casados’ son-in-law, a deputy director of finance;
- Casados’ granddaughter, a case aide to support the investigation, permanency, and placement units;
- Casados’ granddaughter’s boyfriend, a supervisor at Hope House, an all-female congregate care facility;
- Casados’ friend, an investigations supervisor—who had recently left law enforcement following disciplinary action—and was personally recommended to the hiring manager by Casados; and
- Jonathan Salazar, a contractor tasked with improving foster family recruitment and retention, who Casados hired in part due to a prior working relationship with his mother.

Secretary Casados’ resignation in September 2025 created an opportunity to reset CYFD’s leadership. Instead, a long-time CYFD employee and former deputy secretary was elevated to Acting Secretary, a move that signals a continuation of the same leadership approach that has long failed to deliver better outcomes for children. The absence of effective leadership at CYFD underscores the urgent need for experienced and principled professionals who can rebuild public trust and refocus the Department on its core mission.

b. CYFD has cultivated a culture of insularity and resistance to transparency and accountability.

Former staff described CYFD’s culture as toxic, punitive, and insular—marked by a “control mindset” and a “circle the wagons” approach that discouraged transparency. Despite legislative efforts to curb excessive reliance on confidentiality restrictions,⁵⁸ CYFD continues to invoke these protections in ways that promote secrecy and hinder accountability. Indeed, CYFD leadership routinely cites confidentiality as a blanket justification for withholding information—even when such claims lack any legitimate legal basis.

CYFD has repeatedly failed to act transparently—toward external oversight bodies, internal monitors, its own staff, the courts, and the public at large—even when mandated by law to share information. CYFD’s attempts to thwart legitimate oversight include:

- Submitting incomplete records, contracts, and supporting documentation to the Office of the State Auditor (OSA) during its preliminary review of CYFD’s alleged misuse of appropriated funds;
- Ignoring five separate document requests from *Kevin S. Co-Neutrals* related to the fatality review of teenagers who died in state custody;⁵⁹
- Denying pertinent internal abuse and neglect records to the New Mexico State Police Department as part of a criminal investigation;
- Providing incomplete foster care records during CYFD’s fiscal year (FY) 2024 independent audit;⁶⁰ and
- Engaging in prolonged delays and minimal disclosures in response to multiple NMDNJ inquiries, flouting its legal obligation and stated commitment to cooperate with the investigation.

CYFD’s aversion to accountability is equally evident in its approach toward internal monitors and employees. For example, CYFD created the Office of Children’s Rights (OCR) in 2021 to ensure the Department adhered to the New Mexico Foster Child and Youth Bill of Rights.⁶¹ The OCR established a grievance process that enabled caregivers and youth to file

⁵⁸ In 2025, the Legislature amended NMSA 1978, Section 32A-4-33 to broaden disclosure authority. Subsection (B) now states that “the public release of department information shall be construed as openly as possible under federal and state law.”

⁵⁹ Implementation of the State’s obligations under the *Kevin S. Settlement Agreement* are monitored by two Co-Neutrals. The Co-Neutrals, who were selected for their expertise in child welfare issues, function in a neutral capacity and have the authority to validate, evaluate, and audit progress toward achievement of Performance Standards under the agreement.

⁶⁰ Auditors considered CYFD’s lack of supporting documentation for Title IV-E foster care expenditures a material weakness and material noncompliance.

⁶¹ CYFD, [*New Mexico Foster Child and Youth Bill of Rights*](#) (2021).

complaints about CYFD practices, leading to internal reviews, formal reports, and actionable recommendations to leadership.⁶² The NMDOJ spoke with a former children’s rights specialist with the OCR who reported that they received little cooperation from CYFD staff and no meaningful support from executive leadership. Upon Secretary Casados’ arrival, the OCR was instructed to halt all investigations and stop issuing written findings or recommendations—seemingly aimed at eliminating any documentation that might be accessible through public records requests. With OCR’s core mission dismantled and the office rebranded as an “Office of Advocacy,”⁶³ many experienced employees chose to leave the Department altogether.

Former CYFD Deputy Director of Permanency Romaine Serna and other former employees also reported that CYFD leadership regularly dismissed staff input. Serna, who oversaw Bernalillo County’s permanency division from June 2024 to May 2025, recalled that Secretary Casados disregarded the expertise of the Departments’ child welfare professionals and “insisted on doing things her way.” When Serna raised concerns that hiring unlicensed social workers could endanger families and expose the agency to legal risk, Casados reportedly responded: “Do not ever bring that up with me again.”

In other instances, several CYFD employees were fired, reprimanded, or pressured to resign after raising legitimate concerns about the Department’s sole-source contract with Binti Inc.—a California-based firm with ties to former Secretary Brian Blalock—to upgrade the Department’s outdated computer system. It was reported that CYFD bypassed a competitive bidding process, prompting internal objections about transparency and legal compliance.⁶⁴ Employee concerns were clearly justified. Despite initial projections of a \$36 million cost and completion by October 2022, the case management system overhaul has ballooned to an estimated \$90.4 million project that has been delayed until, at present, November 2027.⁶⁵ CYFD’s response to these well-intentioned concerns, however, reinforced its internal culture of intimidation.

Beyond resistance to internal oversight, CYFD has even disregarded accountability efforts from the judiciary. A guardian ad litem (GAL) who regularly appears in Children’s Court described how CYFD attorneys and PPWs are frequently fined for infractions such as failing to appear in court or submitting reports late. According to the GAL, some CYFD staff openly admit they don’t care about being fined or held in contempt, even joking about it. The GAL

⁶² The OCR addressed recurring issues including excessive placements, missed school, delays in medical appointments, lack of case notes, and unmet disability accommodations.

⁶³ [KOB 4 Investigates: What Happened to CYFD’s Office of Children Rights?](#), KOB 4 (July 17, 2024).

⁶⁴ Ed Williams, [Questions of Fairness](#). Searchlight New Mexico. (July 22, 2021).

⁶⁵ Legislative Finance Committee, [LegisStat Report on Child Maltreatment](#) 13 (June 25, 2025) (hereinafter “LFC Report on Child Maltreatment”)

further noted that the Court rarely enforces any penalties, enabling CYFD’s disregard for judicial oversight. Additionally, the NMDOJ spoke with a court-appointed special advocate (CASA)⁶⁶ who described feeling constrained in pushing CYFD to improve, noting that her local CASA program was reluctant to challenge the Department due to its ongoing working relationship.

Further, CYFD’s actions suggest a pattern of evading scrutiny from the public it’s designed to serve. Multiple foster parents reported that CYFD’s Office of Constituent Affairs routinely failed to address their concerns. Even when efforts were made, CYFD supervisors often responded defensively or engaged in retaliatory behavior against foster parents. Additionally, the Department is frequently slow or overly restrictive in producing documents under the Inspection of Public Records Act (IPRA). At times, CYFD has even misrepresented its own policies to justify decisions, providing the media and public incomplete or inaccurate information to avoid accountability.

For example, in one case involving repeated abuse and neglect of four children in Albuquerque, CYFD incorrectly claimed that removing the children from the abusive home required law enforcement’s concurrence, despite the existence of other legal avenues.

Table 1. *Discrepancy between CYFD’s stated removal requirements and CYFD policy. Created by NMDOJ.*

CYFD’s Claim	CYFD’s Policy
CYFD’s Communications Director: “CYFD can remove a child from a home only if there is an active threat to their safety and in which law enforcement agrees and gives us custody, which was found only in the October 2025 instance.” ⁶⁷	<i>PR 16, Section 5:</i> Removal may occur at any time during the investigation when the worker, in consultation with the supervisor, the county office manager (COM) and the [C]hildren’s [C]ourt 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 <u>or through court order</u>, unless the child is already in the custody of PSD.⁶⁸ <i>PR 10, Section 5.5:</i> When a child has been assessed to be unsafe, a petition for custody can be filed. The worker, in consultation with their supervisor and CCA, prepares an affidavit requesting custody. The CCA seeks an Ex-Parte Order from the court. Upon receipt of the order, worker collaborates with law enforcement to implement the order.⁶⁹

⁶⁶ A court-appointed special advocate assists the court in determining the best interests of the child by investigating the case and submitting a report with recommendations. NMSA 1978, § 32A-1-4(F).

⁶⁷ Jordan Honeycutt, [Albuquerque couple facing multiple child abuse charges](#), KRQE News. (Nov. 12, 2025).

⁶⁸ CYFD Invest. Proc. PR 16, § 5.

⁶⁹ CYSD Invest. Proc. PR 16, § 5.5.

Only two possibilities exist: either CYFD is unaware of its legal authority to seek an *ex parte* removal order for a child in danger, or it knowingly misled the media to shift blame onto law enforcement and avoid responsibility. CYFD has shown a persistent unwillingness to confront its own shortcomings, choosing secrecy and deflection over the urgent need to improve child safety.

c. *CYFD leadership has failed to prioritize compliance with the Kevin S. settlement agreement.*

In 2018, 14 foster children in New Mexico, along with non-profit agencies Disability Rights New Mexico and the Native American Disability Law Center, filed *Kevin S. v. Jacobson*,⁷⁰ a lawsuit against CYFD and the Human Services Department (HSD). The suit alleged that trauma-impacted children in foster care lacked safe and stable placements and behavioral health services to meet their needs. In March 2020, the parties entered into a [final settlement agreement](#), by which CYFD and HSD (now, the Healthcare Authority or HCA) committed to more fully meeting the needs of New Mexico’s foster youth. Two unaffiliated Co-Neutrals monitor CYFD’s compliance and publish annual reports evaluating the Department’s performance. Several of their relevant findings are referenced throughout this report.

Specifically, the Co-Neutrals annually determine whether CYFD has made good faith efforts to achieve sustained progress toward 42 targeted outcomes (TOs) across four distinct areas: trauma-responsive system of care; least-restrictive and appropriate placements; Indian Child Welfare Act; and behavioral health services. CYFD has shown a steady decline in meeting these key metrics over the past three years. In 2022 and 2023 CYFD met performance standards for only 12% and 5% of the TOs, respectively. By 2024, CYFD and HCA did not meet performance standards for any of the 42 TOs under the settlement agreement. The Co-Neutrals stated:

“The [2024] report reflects a state system in unyielding crisis that lost significant ground, with multiple examples throughout these pages of worsening performance and deteriorating experiences and outcomes for children.”⁷¹

The NMDOJ is deeply concerned by CYFD’s apparent lack of urgency in fulfilling its obligations under the *Kevin S.* settlement. A former county office manager described how

⁷⁰ [Complaint](#), *Kevin S. v. Jacobson*, No. 1:18-cv-00896. (D.N.M. Dec. 28, 2018).

⁷¹ Judith Meltzer and Kevin Ryan, [Co-Neutrals’ 2023 Annual Report: Kevin S., et al v. Blalock and Scrase](#) 10, Center for the Study of Social Policy (Nov. 14, 2025) (hereinafter “*Kevin S. 2024 Co-Neutrals’ Annual Report*”).

CYFD's frontline staff are often unclear or wholly unaware of what the agreement requires. It is not the responsibility of frontline staff to immerse themselves in the details of litigation—rather it is incumbent on leadership to champion reform and ensure that the commitment is clearly communicated and ingrained throughout the Department. Staff confusion or apathy reflects a leadership culture that neither expects to be held meaningfully accountable for its failures, nor embraces the settlement's requirements as integral to strengthening the child welfare system.

2. Acute social worker shortage within protective services.

CYFD faces significant workforce challenges, struggling to hire enough employees to meet the demands of the state's child welfare system. Even when vacancies are filled, the Department frequently hires individuals who lack the professional training and credentials required for effective child welfare practice, leading to poor-quality work that places children and families at risk.

During an arbitration to address outstanding issues in the *Kevin S.* litigation, Charles Sallee, Director of the Legislative Finance Committee (LFC), highlighted CYFD's critical workforce issues. These included high turnover, management's inability to re-allocate work after employee departures, staff de-professionalization, and widespread burnout.⁷² In August 2025, a *Kevin S.* arbitrator stated that "stabilizing a well-trained workforce must be treated as a top priority that is profoundly overdue."⁷³

Director Sallee acknowledged the LFC staff's longstanding concerns regarding the qualifications and suitability of CYFD's workforce. He stated:

"Years ago there was a prioritization for licensed social workers to do much of the protective services frontline work. There were decisions—policy decisions made within the Department . . . to not prioritize hiring licensed social workers and not even requiring it. I don't think the job description even requires a college degree anymore. And what we were seeing was a dramatic shift to hiring people who didn't have a professional background in this type of child welfare work, contributing to greater turnover, because they are hiring people with related degrees but they were not prepared to do this kind of very difficult work."⁷⁴

⁷² Trans. Charles Sallee 104:1-8 (Day 3 of Arbitration), *Kevin S. v. N.M. Children, Youth and Families Dep't.* (Nov. 8, 2024) (hereinafter "Sallee Transcript").

⁷³ [Arbitrator's Remedial Order. No. 2](#) 9, *Kevin S. v. N.M. Children, Youth and Families Dep't.* (Aug. 18, 2025) (Peifer, Arb.).

⁷⁴ Sallee Trans. at 103:3-17 (Day 3 of Arbitration) (Nov. 8, 2024).

Former CYFD employees echoed concerns about the Department’s hiring practices. In her [May 2025 resignation letter](#), Deputy Director Serna warned Secretary Casados that rapid hiring events in Bernalillo County brought in staff lacking qualifications and commitment to skill development. In her interview with the NMDOJ, Serna described alarming incidents involving new staff, including one employee smoking marijuana with a child during transport, and another arriving drunk to a home visit. Two other former managers described similar experiences with the Department’s hiring—emphasizing that CYFD hired individuals unsuited for child welfare work despite explicit internal objections.

Accounts from these CYFD employees and others reveal a self-reinforcing hiring crisis. Faced with high caseloads and poor retention, CYFD lowers employment standards to quickly fill vacancies, often hiring individuals without relevant credentials or experience. New hires lacking proper training and supervision make harmful decisions that delay permanency, impair investigations, and negatively impact children and families. The ensuing poor outcomes—often publicly-reported child deaths—erode CYFD’s credibility and internal morale. This cycle encourages CYFD’s culture of secrecy and retaliation and impedes its ability to recruit future employees.⁷⁵ For those employees that remain, they experience burnout and job dissatisfaction. As workload intensifies, the cycle continues.

Breaking this cycle will require CYFD to make a deliberate and sustained investment in recruiting licensed, mission-driven social workers. By offering competitive salaries, and clear pathways for advancement, the Department can hire and empower qualified professionals to make sound decisions and deliver services more efficiently. As workloads become more manageable and results improve, CYFD’s reputation will strengthen, further enhancing its ability to attract and retain talent. Ultimately, a positive, self-reinforcing hiring cycle is established. Indeed, LFC staff have noted that “a well-prepared, trained, and supported workforce of professional social workers can improve outcomes.”

Between June 2024 and February 2025, CYFD reported that only 7% of its protective services (PSD) workforce held social work licenses.⁷⁶ Similarly, a comparison of CYFD’s December 2025 employee roster with the state’s Regulation and Licensing Department database confirms that actively licensed social workers remain critically underrepresented at CYFD.⁷⁷ This includes:

⁷⁵ CYFD’s poor reputation has impacted recruitment. [One aspiring social worker](#)—serving as a foster placement and frustrated with CYFD’s lack of responsiveness—shared that CYFD is a “horrible organization” and that current CYFD employees advised him to not work there upon graduation.

⁷⁶ LFC Report on Child Maltreatment at 5.

⁷⁷ This review included all available social work licenses, namely: licensed clinical social worker (LCSW), licensed masters and baccalaureate social worker (LMSW/LBSW), licensed independent social worker (LISW), and provisional licenses.

- 379 front-line and senior PSD employees, of which 16 maintained social work licenses (4.22%); and
- 143 PSD supervisors and managers, of which 26 maintained social work licenses (18.18%).⁷⁸

CYFD leadership and the Board of Social Work Examiners should also evaluate whether the Department’s hiring practices align with the Social Work Practice Act,⁷⁹ which prohibits unlicensed individuals from engaging in the practice of social work. The Act defines social work as “a professional service requiring specialized knowledge of social resources, social systems and human capabilities to effect change in human behavior, emotional responses, and social conditions.”⁸⁰ Given the nature of work performed by CYFD investigators and PPWs, it appears difficult—without resorting to superficial title changes—to distinguish their duties from those defined as social work under the statute.

CYFD does report ongoing efforts to recruit and retain licensed social workers. In an LFC hearing on June 25, 2025, Secretary Casados stated that CYFD staff attended job fairs at 11 universities in surrounding states to attract social work students to New Mexico.⁸¹ Further, in 2024, CYFD provided a 10% temporary salary increase (TSI) for licensed social workers to support retention. This incentive expired however on June 30, 2025.⁸²

The timing of the TSI expiration is particularly concerning considering other costs incurred by the Department around this same period. Two months prior to the TSI ending, [CYFD emails indicate plans to spend \\$914,888.80](#) on leadership training, including a \$40,000 executive retreat. The training aimed to enhance “building relationships, communication, and trust with each other and with staff across the state” and to “support retention activities for current staff...” With a proven mechanism for improving employee satisfaction and incentivizing retention, CYFD may have been better served by exploring ways to repurpose this nearly \$1 million expenditure.

Despite consistent legislative appropriations to support targeted recruitment of licensed social workers and encourage existing staff to pursue master’s-level licensure,⁸³ there has not been a meaningful increase in the number of social workers at CYFD. As CYFD

⁷⁸ The results of this study were reached by filtering staff list to include CPS, Sr. CPS, Mgr. CPS, Sr. Mgr. CPS, and Supv. CPS caseworkers. Although this data is drawn from CYFD’s own employee records, inconsistencies in how the Department collects and manages information raise concerns about its reliability. Any conclusions drawn from this data therefore warrant caution.

⁷⁹ NMSA 1978, §§ 61-31-1 to -25.

⁸⁰ NMSA 1978, § 61-31-6(B).

⁸¹ Legislative Finance Committee Hearing, Trans. 20:23-25, 21:1-5 (June 25, 2025).

⁸² Legislative Finance Committee Hearing, Trans. 110:6-111:3 (June 25, 2025).

⁸³ LFC Report on Child Maltreatment at 6.

seeks to expand its workforce, priority should be given to placing social workers in county office manager and other leadership roles, as their expertise uniquely equips them to shape policies that reflect child welfare best practices.

Multiple stakeholders also underscored the importance of forging a more intentional and sustained collaboration between CYFD and higher education institutions to ensure the steady development of in-state social workers. While CYFD has pointed to advancements in this area, LFC staff believe more meaningful action is still needed, noting:

“We were concerned about the pipeline that didn’t seem adequate in terms of partnerships with schools of social work and leveraging federal funds for those educational programs to bring people in as they are studying social work to start doing practicums and internships with protective services to help expose them early on to what they’d be getting involved in and make sure that they’re adequately prepared to do the work.”⁸⁴

Although CYFD offers federally funded stipends to social work students at New Mexico’s higher education institutions—along with extensive field training and guaranteed employment upon graduation—many choose to leave the Department anyway. One social work professor at a New Mexico university familiar with this program noted that students frequently cite CYFD’s workplace culture and office environment as deterrents to remaining with the organization. Some student even opt to repay their stipends on aggressive schedules just to avoid continuing to work for even a short period of time at CYFD. Although there is a social worker shortage within the state, this problem is exacerbated by a dysfunctional internal environment that young professionals are actively choosing to avoid.

There is simply no substitute for the experience in client assessment that licensed social workers bring to child welfare. Although CYFD has taken steps to hire more qualified staff, its current strategy lacks the urgency and depth needed to meet the scale of the crisis. Many non-social workers join the Department with energy and commitment, and such employees are not without merit—but without either the tools that social work education provides or a robust training and supervision regimen, they are set up to fail. The consequences—failures in assessments and resource delivery, missed warning signs, and ultimately preventable harm—are not inexplicable; they are the result of intentional organizational decisions. CYFD must no longer delay. The time to hire qualified social workers is now, before more children are placed at risk.

⁸⁴ Sallee Trans. at 103:18-25 (Day 3 of Arbitration) (Nov. 8, 2024).

3. Barriers to employee retention.

Recruiting qualified social workers is only part of the solution. Without ongoing investment in their growth and retention, CYFD will continue to struggle with an inexperienced workforce. This challenge is familiar, with high rates of staff attrition that have consistently disrupted CYFD's capacity to effectively fulfill its mission. Turnover among protective services workers has equaled or exceeded 25% for more than a decade, and has remained over 30% for three consecutive years. This turnover is even more pronounced when it comes to senior investigators, PPWs, and supervisor positions. While turnover for child welfare workers remains a problem nationally, rates at or below 12% are considered optimal. Despite active hiring efforts, CYFD saw a net gain of only 20 protective services workers between June 2024 and June 2025 due in part to ongoing retention challenges.⁸⁵

Turnover Rate for Protective Service Workers

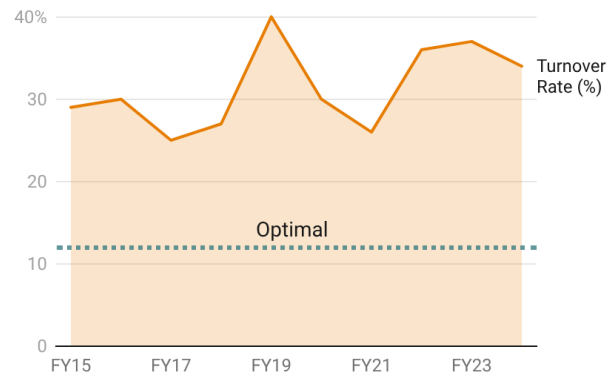


Figure 4. Turnover rate for PSD workers, FY'15-FY'24. Reproduced from LFC LegisStat report (December 10, 2024).

CYFD's data indicates particular difficulty retaining newer employees, with evidence suggesting that those who remain beyond their third year are more likely to stay long-term. In 2024, 84 PSD investigators or PPWs voluntarily terminated their employment with CYFD, and nearly half (45%) had been employed for less than one year:⁸⁶

Table 2. Length of tenure before termination for eligible employees. Reproduced from Kevin S. Co-Neutral 2024 Annual Report.

Length of tenure before voluntary termination	No.	%
Less than one year	38	45%
1 to 3 years	31	37%
4 to 6 years	6	7%
7 to 9 years	6	7%
10 or more years	3	4%
Total	84	100%

CYFD staff turnover stems from a range of organizational deficiencies. While pay is often assumed as a primary factor, salaries for protective services employees have

⁸⁵ LFC Report on Child Maltreatment at 2.

⁸⁶ Kevin S. 2024 Co-Neutrals' Annual Report at 115.

increased by 37% since 2020—well outpacing regional averages⁸⁷—yet retention remains a challenge. Former employees in Bernalillo County cited mandatory overtime to supervise children in offices as a major source of job dissatisfaction. Foster parents also described a culture of emotional exhaustion, with PPWs expressing deep frustration, sometimes breaking down in tears due to the lack of support. These concerns reflect broader morale issues, including reports of bullying, retaliation, and even the recent suicide of a front-line investigator whose colleagues attributed the loss in part to severe workplace mistreatment.⁸⁸

Compounding the issue, there is a sentiment that high-performing staff were often overworked and overlooked, while underperformers were promoted, fueling feelings of inequity and burnout. A 2023 CYFD employee exit survey noted leadership as a central concern, with nearly one in five employees citing it as their primary reason for leaving.⁸⁹ Interviews conducted by the NMDOJ identified three additional core barriers to retention: (1) unsustainable caseloads; (2) inadequate training; and (3) a lack of effective supervision.

a. Unmanageable caseloads accelerate staff turnover.

As part of CYFD’s workforce development plan required under the *Kevin S.* settlement agreement, employee caseload standards were established, including gradual caseload increases based on time since new employee training (NET) completion. For employees who completed NET more than six months prior, maximum caseloads were as follows:

- Investigators: 12 investigations;
- PPWs: 15 children;
- Licensing and support specialists (previously “placement workers”): either 15 adoption cases, 20 licensed families, or 15 home studies; and
- In-Home Services (IHS): 8 cases.⁹⁰

By the end of 2023, CYFD committed to ensuring that no PSD employee would carry more than 200% of the established maximum caseload standard under *Kevin S.* requirements. Additionally, certain roles—including supervisors, case aides, administrators, and directors—would be ineligible for primary case assignments.⁹¹ CYFD has not met that commitment. According to the 2024 *Kevin S.* Co-Neutral annual report, with

⁸⁷ LFC Report on Child Maltreatment at 2; Sallee Trans. at 97:4-15 (Day 3 of Arbitration) (Nov. 8, 2024).

⁸⁸ Esteban Candelaria, [CYFD workers: Fear and oppressive caseloads continue at New Mexico child welfare offices](#), Santa Fe New Mexican (March 16, 2026).

⁸⁹ *Id.* at 5.

⁹⁰ [Arbitration Decision and Award](#) 13–14, *Kevin S. v. N.M. Children, Youth and Families Dep’t.* (Aug. 18, 2025) (Peifer, Arb.) (hereinafter “*Kevin S. Arbitration Decision and Award*”).

⁹¹ *Id.* at 13–14.

the exception of IHS, the share of eligible workers with compliant caseloads never exceeded 50%:⁹²

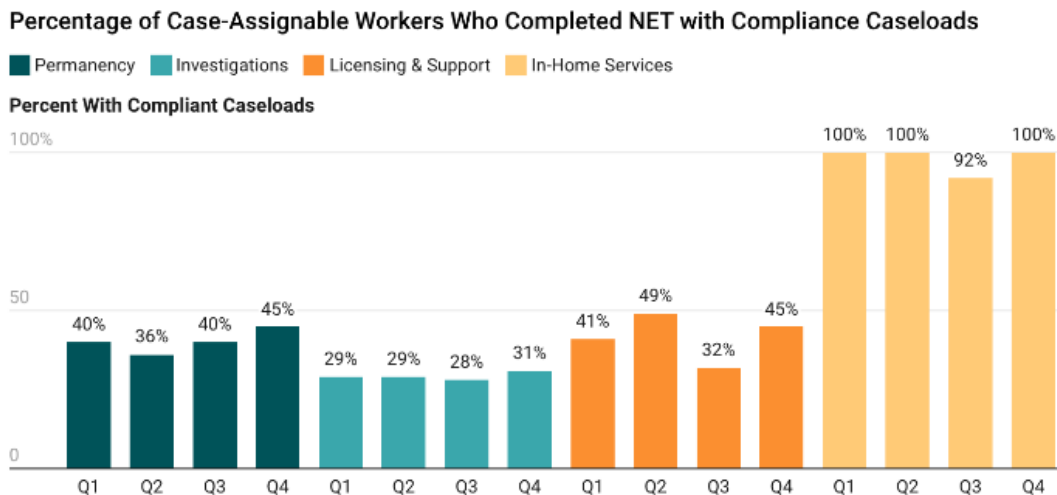


Figure 5. Percentage of workers who completed New Employee Training with compliant caseloads by quarter and unit. Reproduced from Kevin S. Co-Neutrals’ 2024 Annual Report.

Further, despite being ineligible for primary case assignments, a significant number of such individuals—primarily supervisors—were assigned cases during 2024. Additional case flow problems arose when cases were either assigned to employees who had already left CYFD or left unassigned altogether.⁹³

Table 3. Summary of all case types assigned to non-case-assignable staff by quarter in 2024. Reproduced from Kevin S. Co-Neutral 2024 Annual Report.

	Mar. 31 Q1	Jun. 11 Q2	Sept. 6 Q3	Dec. 3 Q4
Total cases:	5,648	5,413	5,445	6,221
Total cases assigned to non-case-assignable staff	1,222	806	661	910
Percent of cases assigned to non-case-assignable staff	22%	15%	12%	15%
Total unassigned or assigned to terminated worker	421	163	123	182
Total assigned to non-case-assignable worker	801	643	538	728

Unsurprisingly, former CYFD employees uniformly told the NMDOJ that unmanageable caseloads were a major reason for leaving the agency. At the time of her resignation in May 2025, Deputy Director Serna reported that permanency caseloads exceeded 50 children per PPW, with just 12 PPWs handling over 700 cases, far exceeding the maximum 15 children per PPW standard. By August 2025, witnesses described permanency caseloads in Bernalillo County rising above 60 per worker. One investigator shared that she had 150 open investigations at one point—more than ten times the maximum standard—

⁹² Kevin S. 2024 Co-Neutrals’ Annual Report at 111–112.

⁹³ Kevin S. 2024 Co-Neutrals’ Annual Report at 112–113.

and another recalled being assigned nearly 100 overdue cases on her second day. Staff described being unable to perform their duties effectively.

Caseloads for investigators also remain well above established standards. Although CYFD created Emergency Response Investigation positions to provide additional staffing capacity—particularly to respond to after-hours emergencies and supplement on-call responses—only 62% of those positions were filled by December 2025.⁹⁴ Among these Emergency Response investigators, only one of the five interviewed by *Kevin S. Co-Neutrals* had started working the 11:00 p.m. to 8:00 a.m. shift for which they were hired due to extensive investigator vacancies.⁹⁵

According to the LFC’s FY 2026 budget recommendations, CYFD requested general fund increases to include \$7 million to fill an additional 101 positions to meet *Kevin S.* commitments.⁹⁶ The LFC found that CYFD could hire 13 full-time protective services staff if it drew down federal funds at the levels already budgeted. In addition, the LFC noted that a special appropriation in FY 2023 intended for workforce development remained unspent.⁹⁷ As of December 2025, CYFD reported that it expected to have 132 net new caseworkers⁹⁸ by the end of 2025—a positive step, but one acknowledged by CYFD leadership as “still not nearly enough to meet our caseload requirements.”⁹⁹

These workforce deficiencies have serious consequences. A recent LFC evaluation highlighted federal research showing that staffing shortages have a detrimental effect on a worker’s ability to make well-supported and timely decisions regarding children’s safety.¹⁰⁰ Former CYFD investigators described persistent pressure to close cases quickly in order to reduce caseloads—often at the expense of conducting thorough, professional investigations. If CYFD can recruit skilled professionals and commit to retaining them, caseloads will decline, leading to safer outcomes for children and stronger support for families across New Mexico.

⁹⁴ January 30, 2026 *Kevin S.* Report, at 2-3, 5.

⁹⁵ *Id.* at 5.

⁹⁶ LFC 2026 FY Appropriations Recommendations at 347, 349.

⁹⁷ *Id.* at 349.

⁹⁸ When this report uses the term “caseworker,” it reflects the terminology used by the source, or serves as a catch-all reference to both protective services investigators and PPWs.

⁹⁹ Esteban Candelaria. [CYFD makes some gains but unlikely to meet recruitment goals](#), Santa Fe New Mexican. (Dec. 1, 2025).

¹⁰⁰ LFC 2026 FY Appropriations Recommendations at 349.

b. Continuous and targeted training, while essential for employee success, is unavailable.

Amid high caseloads and a social worker shortage, effective training provides the critical foundation employees need to professionally navigate complex child welfare issues. In contrast, recent CYFD staff described the NET as overly generalized and focused on investigations, leaving PPWs and others without relevant preparation. One CYFD manager criticized a recent training overhaul as superficial, stating that leadership altered logistics without improving the curriculum—a move they described as “rearranging deck chairs on the Titanic.” Even CYFD’s mentorship program has been questioned for assigning mentors who lack adequate field experience themselves, further undermining training efficacy.

In some cases, CYFD employees are assigned cases before fully completing their training. One PPW told the NMDOJ that she was pulled from NET to attend hearings and perform other duties, leaving her without the knowledge needed to manage cases effectively. CYFD’s premature case assignment was corroborated by the *Kevin S. Co-Neutrals*, who identified 10 individuals assigned as primary caseworkers before NET completion.¹⁰¹ This practice not only compromises the quality of investigations and permanency case management, but also places unprepared staff in high-pressure situations that contribute to burnout and turnover.

The federal government has echoed these concerns. The 2025 Child and Family Services Review (CFSR) rated CYFD’s initial and ongoing staff training as an “area needing improvement.” The review found that NET is not consistently completed in a timely manner and fails to equip new employees with the skills needed to assume their duties. Ongoing training is similarly lacking, with high caseloads and staff vacancies preventing participation in available programs.¹⁰² CSFR’s findings are reinforced by the 2024 Co-Neutral Report, which revealed that over a quarter of staff required to receive trauma-responsive training had not taken this training—despite the critical importance of trauma-informed care in child welfare settings.¹⁰³

c. Inconsistent or absent supervision leaves investigators and PPWs unsupported and overwhelmed.

Effective supervision serves as the anchor to high-quality child welfare practice—without it, employees feel isolated and are more likely to make uninformed or haphazard

¹⁰¹ *Kevin S.* 2024 Co-Neutrals’ Annual Report at 112.

¹⁰² U.S. Admin. for Children & Families, [Child and Family Services Reviews New Mexico Final Report 2025](#) 20–21 (hereinafter “CSFR 2025 Final Report”).

¹⁰³ *Kevin S.* 2024 Co-Neutrals’ Annual Report at 46.

decisions that jeopardize child safety.¹⁰⁴ The NMDNJ's investigation revealed that many CYFD protective services employees, particularly those conducting abuse and neglect investigations and engaging in permanency casework, operate with little to no meaningful oversight.

In some cases, even when technically present, supervisors are simply unqualified or disengaged. Several former CYFD employees described supervisors who regularly skipped reviewing case notes, accepted shoddy copied-and-pasted investigation narratives and permanency court reports, or spent much of the day gossiping or shopping. One former county office manager recalled a conversation with a Children's Court judge about a CYFD permanency supervisor who blatantly lied in court. In other cases, supervisors were overwhelmed by their own caseloads, despite *Kevin S.*'s prohibition of this practice. One permanency supervisor reported being assigned 30 of the most difficult cases upon promotion, leaving little time to support her team. Other investigators and PPWs confirmed that supervisors often struggled to manage their employees effectively due to the breadth of their responsibilities.

This lack of support is particularly detrimental given the extensive decision-making authority and meeting responsibilities (referred to as "staffings") entrusted to supervisors under CYFD investigations and permanency policies. Supervisors are obligated to perform some of the most critical functions, including:

- Identifying collateral contacts for interviews and approving exceptions to required interviews or home visits;
- Reviewing and approving safety assessments and safety plans;
- Consulting with investigators regarding removal of a child from a home or returning a child home after a law enforcement hold;
- Providing support in drafting affidavits to seek child custody; and
- Selecting appropriate internal and community-based services for families under investigation.¹⁰⁵

CYFD policy also requires supervisors to hold staffings both before initiating an investigation and again before closing a case. These meetings are designed to review strategies, safety assessments, risk evaluations, referral history, and investigation dispositions. Multiple former CYFD investigators confirmed that staffings are routinely

¹⁰⁴ 8.8.2.27 NMAC ("CYFD Supervisory Framework").

¹⁰⁵ CYFD Invest. Proc. PR 10, § 8.2 ("Required Interviews"), § 8.3 ("Home Visit"), § 8.4 ("Collateral Contacts"), § 9.5 ("Safety Decision"); § 10.1 ("Safety Plans"); PR 16, § 5 ("Seeking or Accepting Custody of Children"); § 5.2 ("Accepting Custody from Law Enforcement"); § 5.5 ("Obtaining *Ex Parte* Custody"); PR 19, § 6 ("Service Options"), § 7 ("Post-Investigation Service Delivery").

skipped. Notably, investigators also shared that supervisors rarely conducted “3+ staffings”—required meetings for families with multiple prior abuse and neglect referrals in order to review history, assess safety risks, and coordinate an approach for family engagement.¹⁰⁶

Even when supervision occurs, it is often ineffective. Foster parents and former staff alike noted that new, enthusiastic caseworkers quickly became disillusioned after exposure to toxic supervision. One foster parent observed that newer caseworkers were undermined by long-tenured supervisors who refused to follow policy. Others described CYFD supervisors and upper management as running the Department “like their own kingdom,” ignoring both internal procedures and legal requirements. A former county office manager told the NMDOJ that many supervisors were unfamiliar with or indifferent to *Kevin S.* deliverables, exposing a disconnect between departmental obligations and frontline practice.

Compounding these issues is the high turnover among supervisors and division directors. In 2023 alone, there were at least three protective services directors or acting directors, making it difficult to maintain a coherent division strategy. One witness described how the permanency unit in Bernalillo County cycled through countless supervisors within a single year—resulting in inconsistent directives, untimely case reassignments, and confusion about expectations. The proper functioning of the system relies extensively on supervisors—when they fail to collaborate with their employees, the Department’s capacity to serve families and protect children is weakened.

4. Investigative failures and the ramifications for child safety.

The effectiveness of CYFD’s response to child maltreatment largely depends on the quality and timeliness of its investigations. Investigations are CYFD’s earliest opportunity to determine whether abuse or neglect occurred, assess child safety, and initiate necessary interventions.¹⁰⁷ When investigations are delayed, incomplete, or poorly executed, the consequences are severe: children remain in dangerous environments, families are denied essential support, and the public’s trust in the child welfare system erodes. Unfortunately, case studies and information from former CYFD employees reveal a pattern of investigative failures.

¹⁰⁶ CYFD Invest. Proc. PR 18, § 5 (“Families With More Than Two Investigations”).

¹⁰⁷ CYFD Invest. Proc. PR 8, § 5 (“Purpose of Child Protective Services Investigation”).

a. Chronic problems in abuse and neglect investigations.

Despite clear investigation protocols, six recurring deviations from these standards hinder CYFD’s ability to address abuse and neglect allegations.

i. Substandard interview practices:

Upon initiating an investigation, CYFD policy requires an interview of the offending parent and all caregivers and children in the household, including the child victim. Investigators must also interview relevant collateral contacts—such as the initial source of the report, medical or other professionals, and witnesses with direct knowledge of the incident—to help corroborate or refute the allegation.¹⁰⁸ A review of CYFD investigations shows that comprehensive interviews are rarely conducted. In several cases, investigators did not interview non-offending primary caregivers, additional children residing in the home, and key collateral sources, limiting their understanding of the family’s circumstances. Investigators also over relied on parental accounts, with minimal effort to verify claims through independent records or third-party witnesses. This lack of corroboration undermined the accuracy of safety and risk assessments and increased the likelihood of overlooking serious threats to the child’s safety.

ii. Failure to conduct required home visits:

Another troubling pattern is the failure to perform mandatory home visits. CYFD policy requires investigators to observe the child in their home environment (including all homes in which they reside) to collect information, assess conditions, and conduct safety assessments as necessary.¹⁰⁹ However, in multiple cases reviewed by the NMDOJ, investigators either failed to adequately examine the child’s home or ignored hazardous conditions that posed serious risks to the child’s health and safety. In instances where a child stayed at multiple locations, there was rarely documented efforts to assess both residences. Former investigations supervisors confirmed that home visits were often skipped entirely—and, in some instances, investigators fabricated documentation to indicate compliance.

iii. Misuse of risk and safety assessment tools:

Further exacerbating the matter, safety and risk assessment instruments¹¹⁰ (known as Structured Decision-Making or “SDM”) are frequently misunderstood or misapplied by CYFD investigators. Although these tools are designed to help investigators identify

¹⁰⁸ CYFD Invest. Proc. PR 10, § 8.2 (“Required Interviews and Observations”), § 8.3 (“Collateral Contacts”).

¹⁰⁹ CYFD Invest. Proc. PR 10, § 8.3 (“Home Visit”).

¹¹⁰ CYFD Invest. Proc. PR 10, § 9.3. Safety assessments measure a child’s danger of *imminent* and serious harm. Risk assessments evaluate likelihood of *future* maltreatment.

dangerous circumstances and determine appropriate responses, inadequate training and inconsistent use compromise their reliability. When SDM tools are not completed or interpreted with fidelity, investigators can miss clear warning signs, underutilize discretionary overrides, and rely excessively on automated outputs instead of applying critical human judgment.

iv. Overreliance on ineffective safety plans:

Safety plans are intended to be short-term, detailed agreements between families and CYFD designed to protect children in their homes when “danger indicators” are present. The plans must identify the specific safety threats, outline steps to mitigate them, and specify individuals responsible for implementation.¹¹¹ Safety plans should include home visits and clear behavioral expectations for caregivers. In practice, however, safety plans are often hollow documents—poorly constructed, lacking sufficient oversight, and used as a convenient option to prematurely close investigations without pursuing appropriate interventions. Deficiencies identified by the NMDNJ include:

- Safety plans left partially incomplete, with missing sections that create confusion about a families’ responsibilities under the plan;
- Plans that fail to address identified safety threats and are used solely to avoid necessary child removal;
- Lack of assigned staff to monitor plans, or failure by assigned staff to sufficiently monitor;
- Expired plans without follow-up services, interventions, or case closure;
- Failure to address key aspects of the child’s life during the pendency of the plan, such as parental visitation, education, and medical decision-making;
- Hasty closure of investigations within the 21-day safety plan period without resolving the dangerous conditions or circumstances;
- Selection of “safety monitors” with substance-abuse or other issues that compromise their ability to oversee the plan;
- Selection of “safety monitors” that maintain close relationships with the biological parents, without any obligation to report plan violations; and
- Complete lack of enforcement of plans when violations occur, resulting in no deterrent for noncompliance.

¹¹¹ CYFD Invest. Pro. PR 10, § 10.1 (“Safety Plans”).

The 2025 federal CFSR review reinforced these concerns, noting:

Safety-related practice improvement needs in New Mexico include caseworkers conducting accurate initial and ongoing assessments of child risk and safety, including obtaining and considering additional case information and case history, identifying all the risk and safety concerns present in the case, and assessing all children residing in the family home. The CFSR also revealed concerns regarding caseworkers not developing safety plans, ensuring that the developed safety plans were adequate to address the identified safety threats, and sufficiently monitoring those plans.

Child safety is of paramount importance and should be a primary focus of New Mexico's PIP. The CB recommends that New Mexico identify strategies to strengthen caseworkers' ability to assess the risk and safety of children accurately and comprehensively and develop, implement, monitor, and adjust appropriate safety plans that mitigate threats to child safety.

Two examples illustrate the flaws in CYFD's use of safety plans. In one case involving a drug-exposed newborn, CYFD drafted a safety plan while the child remained hospitalized. Although policy requires a home visit and reassessment within 21 days, no evaluation occurred, and the case was closed while the safety plan remained active—violating CYFD protocols that mandate legal staffing when danger indicators remain. Shortly after being discharged from the hospital, the infant died in a co-sleeping incident while parents were under the influence of narcotics. This death was entirely preventable, and occurred only after months of CYFD failing to lay eyes on the child in the child's home environment. In another case, a police chief in southern New Mexico recounted an infant's death stemming from a grossly inadequate safety plan. Despite the mother's admission of drug addiction and abandonment of her child, CYFD approved a safety plan that allowed both parents—active meth users—to retain custody, relying solely on their promise to avoid drug use around the baby and leave the child with a sober caregiver if they chose to use drugs. The plan lacked meaningful safeguards, and unsurprisingly failed when the father, under the influence, rolled over and fatally suffocated the child. CYFD must cease reliance on temporary and ineffective fixes, and begin seeking robust, accountable interventions that prioritize child welfare over procedural convenience.

v. Gaps in service coordination for families:

Based on safety and risk assessments and investigation decision, investigators are tasked with connecting families with CYFD or community-based support services.¹¹² Case reviews reveal that service referrals are often either skipped entirely or made without meaningful follow-up, leaving no assurance that families are accessing or benefiting from support. In some instances, investigators lack awareness of available resources, further impairing the referral process. Moreover, voluntary service offerings rarely result in sustained engagement, yet CYFD seldom pursues court-ordered services when necessary.¹¹³ This

¹¹² CYFD Invest. Proc., PR 19, § 6 ("Service Options").

¹¹³ Family in Need of Court-Ordered Services Act, NMSA 1978, §§ 32A-3B-1 to -22; CYFD, [Child Protective Legal Servs. Procedures](#) (8.10.7 NMAC), PR 26 § 8 (2007) (hereinafter "CYFD Legal Proc.").

failure to prioritize and ensure family participation in critical services allows underlying risks to persist and increases the likelihood of future harm.

vi. Unsupported investigative decisions:

CYFD investigators almost universally misapply the low evidentiary threshold required to substantiate abuse or neglect. To substantiate an allegation, the investigator must determine that “credible evidence exists to support the conclusion . . . [that] a child has been abused or neglected.”¹¹⁴ This threshold is significantly lower than the evidence needed for an arrest in a criminal investigation (probable cause) or the standard of proof required in civil litigation (preponderance of the evidence) or criminal prosecution (beyond a reasonable doubt). Yet in practice, investigators conflate these higher standards with their own, resulting in clear instances of abuse or neglect being unsubstantiated. Between March 2024 and March 2025 for example, an average of 76.7% of investigations were deemed unsubstantiated each month.¹¹⁵ The NMDNJ found repeated failures by investigators to substantiate allegations of abuse or neglect despite first-hand witness accounts, information in sworn police affidavits, and observations by teachers or medical providers.

CYFD investigators are also constrained by a binary classification system—“substantiated” or “unsubstantiated”—that fails to capture the full scope of investigative outcomes. Cases may be labeled “unsubstantiated” not because allegations are unfounded, but due to factors like uncooperative caregivers or inability to locate the child. Investigators often misinterpret “unsubstantiated” as indicating factual innocence, overlooking its broader application. This oversimplification risks misleading future assessments and underestimating potential safety threats. Introducing a third category such as “inconclusive” or “unable to determine” would more accurately reflect investigative realities.

b. Consequences of CYFD’s investigative practices.

A sizable backlog of abuse and neglect investigations—stemming from chronic understaffing and insufficient training and supervision—was widely reported by former CYFD employees. According to protective services division data released in March 2025, a substantial share of investigations exceeded the standard 45-day closure timeline. During the final five months of the reporting period, an average of 40% of investigations were overdue.¹¹⁶

¹¹⁴ CYFD Invest. Proc. PR 17, § 5.1 (“Substantiated”).

¹¹⁵ CYFD Protective Servs. Division, [The Last 13 Months: ending March 31, 2025](#) 1 (March 2025) (hereinafter “CYFD March 2025 Report”).

¹¹⁶ CYFD March 2025 Report at 1.

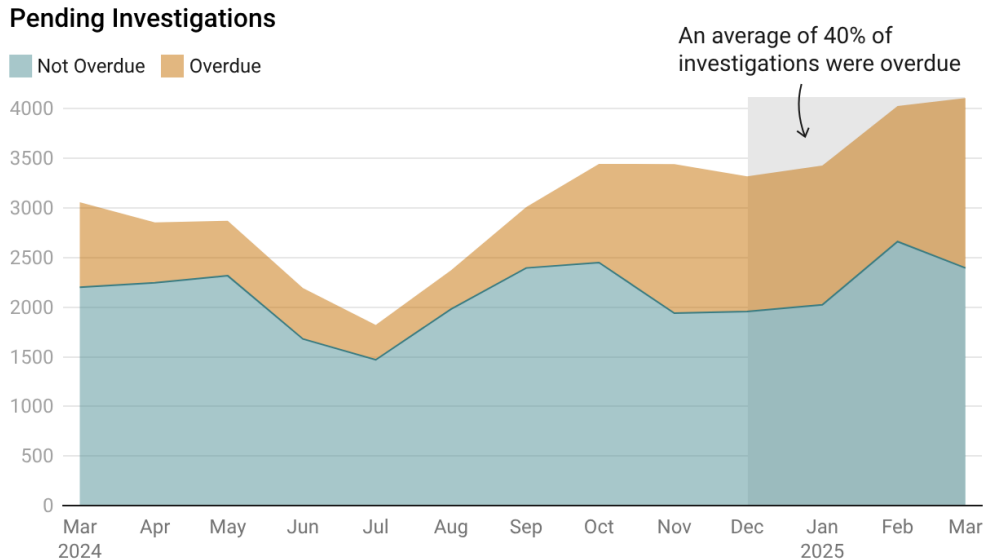


Figure 6. Number of pending abuse and neglect investigations that are overdue as a percentage of the total, March 2024–March 2025. Reproduced from CYFD’s March 2025 Data Evaluation Unit report.

In response, CYFD has placed an emphasis on case closure rates. According to one former employee, investigators were routinely reprimanded by supervisors for not closing cases quickly enough. To address its mounting caseloads, CYFD also launched the “Clear Path” initiative, which resulted in the closure of over 1,300 overdue investigations by November 2025. While reducing caseloads is an important goal, pursuing it as an end in itself—without regard for case complexity or child safety—can lead to premature closures and overlooked risks. A former CYFD investigator told the NMDOJ that the pressure to reduce backlog often incentivized superficial investigations. This cycle actually perpetuates the backlog, as unresolved issues resurface in future abuse and neglect reports.

Other options remain to reduce investigations caseloads. The Department’s ongoing failure to fully implement differential response models despite repeated recommendations from the LFC has exacerbated the problem. When implemented effectively, this approach can ease investigator workloads and reduce repeat maltreatment by diverting lower-risk cases away from full investigations. As recently as June 2025, LFC staff confirmed that the Department continues to fall short in applying these evidence-based approaches as outlined under state law.¹¹⁷

The consequences of investigative inadequacies extend beyond administrative metrics—they directly impact child safety. Numerous accounts from investigators revealed

¹¹⁷ A multilevel response system is required under NMSA 1978, Section 32A-4-4.1; see *also* LFC Report on Child Maltreatment at 4.

a common theme: children are often left in dangerous environments due to caseload pressures, lack of placement options, and misinterpretations of investigative standards. In reviewing case studies, one expert witness documented repeated cases where investigators failed to intervene, even in situations where physical signs of abuse and clear signs of imminent danger were directly observed.

Investigators reported being discouraged from pursuing removals, even in cases involving clear indicators of harm, such as physical injuries, hazardous living conditions, or histories of severe abuse. One former CYFD investigator from southern New Mexico recalled being pressured to leave children in homes with overwhelming amounts of animal waste, serious structural damage, and a lack of basic utilities. Another former investigator cautioned Department leadership that delays in removing children from clearly unsafe homes could have deadly consequences. Such warnings were often fully realized—this report chronicles multiple cases where deficient investigative decision-making resulted in preventable fatalities.

Until investigative standards are strengthened and systemic pressures addressed, children will continue to face avoidable and unacceptable risks.

5. Delays and dangers in permanency planning

CYFD is tasked with meeting strict federal and state timelines to secure stable and permanent homes for children in state custody.¹¹⁸ In practice, CYFD and the Children’s Court routinely disregard these timelines, viewing them as “suggestions” instead of binding legal mandates. Former PPWs and permanency supervisors also report that CYFD consistently fails to deliver the full range of services needed to meet children’s physical, behavioral, educational, and safety needs while in foster care. The 2025 CFSR underscores this failure, ranking New Mexico’s performance on achieving permanency and stability as the lowest of all measured areas:¹¹⁹

New Mexico’s performance on Permanency Outcome 1, Children have permanency and stability in their living situations, was the lowest performing of all the outcome measures at 13% substantial achievement. That performance was driven in large part by performance on Item 6: Achieving Reunification, Guardianship, Adoption, or Another Planned Permanent Living Arrangement. Item 6 had a Strength rating of 23%. Most of the cases in the sample had permanency goals of either reunification or adoption. Concurrent goals were not often used. While 98% of all cases reviewed had permanency goals documented in the files, many were not appropriate at the time of the review, resulting in efforts that were not appropriate to case circumstances and low percentages of permanency achievement. In many of the cases reviewed, a reunification goal was in place for too long and associated with lengthy periods of case circumstances such as non-involvement of the parents in their case plans, absent parents due to homelessness, or attempts to work with parents who indicated their desire not to engage. Further, in many cases with a reunification goal, there was a lack of concerted efforts to engage parents in needed services. Referrals to services were delayed or not made.

¹¹⁸ See 42 U.S.C. §§ 670–679 (Adoption and Safe Families Act); NMSA 1978, §§ 32A-4-1 to -35 (Abuse and Neglect Act).

¹¹⁹ CFSR 2025 New Mexico Final Report at 4.

a. *Breakdowns in permanency planning case management.*

The path to permanency often falters from the outset, as HCA and CYFD fall short in ensuring the physical well-being of children upon initial placement in state custody. Under the *Kevin S.* settlement, every child must receive a “well-child check” within 30 days of entry into CYFD custody. These examinations, performed by qualified medical professionals, are essential for identifying physical and behavioral health needs early so they can be incorporated into treatment plans. Compliance with this obligation was low in 2024—only 53% of children entering CYFD custody received a well-child check within 30 days. For 24% of cases, no well-check was recorded at all.¹²⁰ Between January and November 2025, there were 752 required well-child visits, of which 393 (52%) were timely completed, 259 (34%) were completed late, and 100 (13%) were not completed at all.¹²¹ Data suggests that CYFD made progress in the second half of the year, with 77% of children receiving timely well-child visits.¹²²

While HCA is primarily responsible for delivering necessary physical and behavioral health services, CYFD—as the child’s legal custodian—must work with HCA and Presbyterian health plan care coordinators to identify required services and ensure that each child promptly receives them. When CYFD does not adequately fulfill this role, the consequences are significant: undiagnosed conditions go untreated, and urgent needs remain unaddressed.

Upon a child’s entry into custody, Child and Adolescent Needs and Strengths (CANS) screenings are also required. These evaluations—required within 45 days of removal from the child’s home—are vital assessment tools to identify trauma and behavioral needs, guiding individualized treatment plans. Despite their importance, only 6% of eligible cases in 2024 met this requirement, and four of every five children lacked any record of a completed CANS screening at all.¹²³

Even when assessments are completed, CYFD frequently fails to translate those findings into the services children urgently need. CYFD is obligated to ensure that every child in state custody receives age-appropriate, trauma-responsive services and treatment to meet their needs. These services include intensive case management; intensive home-based or high-fidelity wraparound services;¹²⁴ and trauma-based therapies such as multi-

¹²⁰ *Kevin S.* 2024 Co-Neutrals’ Annual Report at 150–53.

¹²¹ January 30, 2026 *Kevin S.* Report, at 10.

¹²² *Id.* at 11.

¹²³ *Id.* at 34.

¹²⁴ Unlike a traditional single-service model, wraparound services support a family through a team of professionals who collaborate to create a unified support plan.

systemic therapy (MST);¹²⁵ cognitive behavioral therapy (CBT);¹²⁶ and functional family training (FFT).¹²⁷ CYFD has categorically failed in its responsibility—of the more than 3,000 children in state custody at any point during 2024, only 79 unique children (3%) received at least one session of specialized interventions—the lowest rate since 2019. Although 43% of children received behavioral health services to some extent (including psychiatric diagnostic evaluations and crisis or non-crisis interventions), the Department continues to neglect its duty to facilitate access to trauma-focused care.¹²⁸

Interviews held by the NMDOJ corroborate the Co-Neutrals’ findings regarding CYFD’s shortcomings to secure services for children in state custody. One resource family recalled seeking CYFD’s assistance in facilitating an educational assessment for their sixth grader, who was reading at a second-grade level. The family was told by a CYFD PPW that their support for such an assessment would be contingent on the family guaranteeing the child long-term placement. This stance had the effect of conditioning vital services on placement commitments, placing undue pressure on the resource family and compromising the child’s immediate needs. Multiple other foster parents recall pushback or non-responsiveness from PPWs when advocating for resources for children in their care. These anecdotes inform the findings in the CFSR, which conclude that New Mexico is not in substantial conformity with requirements to meet children’s physical and mental health needs.¹²⁹

CYFD’s inability or failure to perform consistent home visits further jeopardizes child safety. Home visits are essential for monitoring living conditions and safeguarding the physical and mental well-being of children in state custody, yet witnesses describe widespread noncompliance. While internal CYFD evaluations claim that home visits occur more than 70% of the time,¹³⁰ not a single PPW interviewed by NMDOJ believed CYFD’s actual performance remotely approached that figure. In fact, former permanency supervisors suggest up to 60% of visits are delayed or omitted entirely. Foster parents confirmed these failures, citing prolonged gaps in PPW contact—two reported that they had not received a home visit for five and seven months earlier. When visits are conducted, a county office manager stated that they are often poorly documented, with copied-and-pasted notes in successive months, creating misleading impressions of home environments. Supervisors suggested remedies, yet nothing changed.

¹²⁵ MST is an evidence-based, family-centered intervention to address antisocial behaviors in youth.

¹²⁶ CBT is a structured, goal-oriented talk therapy that helps people identify and change negative thinking patterns and behaviors to improve how they feel and cope with challenges.

¹²⁷ FFT is a family counseling approach for at-risk youth with behavioral issues focusing on changing unhelpful interaction patterns, improving communication, and building family strengths.

¹²⁸ Kevin S. 2024 Co-Neutrals’ Annual Report at 41–42.

¹²⁹ CFSR 2025 New Mexico Final Report at 4–5.

¹³⁰ CYFD March 2025 Report at 3.

Deputy Director Romaine Serna's resignation letter to Secretary Casados underscored the lack of support from cabinet leadership in tackling the problem. Serna wrote:

"[T]he greater risk to families and to the department are the perm[anency] cases. We have custody of those kids and are responsible for their safety. Our legal exposure is something to consider. There are not enough bodies to conduct home visits. I asked for a 'strike force' to assist with home visits. Created a map with zip codes where our kids were placed, making it easier to get volunteers to assist with the visits. Never was approved."

Former PPWs and other stakeholders identified additional concerns about CYFD's handling of cases of children in state custody. These include:

- No warm hand-off between units—once children enter CYFD custody, there is no structured transition or communication between the investigator and PPW, creating gaps in case knowledge and continuity;
- Failure to regularly assess levels of care—CYFD does not timely reevaluate and adjust children's level of care, despite evident shifts in a child's needs and circumstances;
- Excessive transportation duties—Particularly in rural areas, PPWs spend disproportionate time transporting children, reducing capacity for core case management tasks;
- Neglect of educational needs—PPWs often miss individualized education program (IEP) meetings, creating advocacy gaps and contributing to foster youth's extremely low graduation rates; and
- Disingenuous use of children's federal benefits—CYFD continued using children's Social Security benefits for foster care expenses through 2025, despite a [July 2023 directive](#) banning the practice. It ceased only after state law mandated compliance.¹³¹

These failures—from missed health screenings and inadequate trauma-focused services to gaps in home visits and case management—deepen the insecurity and unpredictability experienced by children navigating foster care.

b. Procedural and legal failures that prolong permanency decisions.

¹³¹ Esteban Candelaria, [CYFD no longer using federal benefits to pay for care it was already required to provide, agency says](#), Santa Fe New Mexican (Sept. 8, 2025).

New Mexico’s Children’s Code mandates strict timelines for resolving abuse and neglect allegations. If abuse or neglect has occurred, the Code requires periodic reviews to protect children from ongoing instability and expedite a child’s path to family reunification or placement in a safe, permanent home. Extended stays in foster care cause serious problems—they are strongly associated with adverse outcomes, including academic difficulties, impaired impulse control, drug abuse, unstable relationships, increased rates of incarceration, and elevated suicide rates.¹³²

Foster families and former CYFD staff reported that permanency delays often result from PPWs failing to appear in court to provide case updates, causing repeated hearing continuances and prolonged timelines. One foster parent told the NMDOJ that “it is extremely common for CYFD to not show up to court,” and another reported that judges are frequently admonishing the Department for its lack of effective case management. One youth attorney familiar with abuse and neglect cases stated:

“We have cases where the judges are making us come in weekly, essentially to scold CYFD about their lack of movement on cases where kids should be adopted.”¹³³

Delays in proceedings also stem from absent or incomplete court reports that PPW’s are required to submit prior to permanency hearings. Supervisors note this has been a persistent issue, as report writing frequently falls to the bottom of a PPW’s priorities amid competing tasks. Even when filed, reports are often inadequate—short-form filings omit critical details, factual misstatements are common, and key information such as treatment plan compliance is omitted. These gaps force judges to rely on oral testimony, which is often flawed because PPWs are newly assigned, have not completed visits, or lack case familiarity. Supervisors also cite poor coordination between CYFD attorneys and PPWs, where hearing dates are communicated late, resulting in last-minute, rushed reports.

These incidents are not outliers—they track federal observations of chronic continuances that delay permanency decisions. New Mexico’s 2025 CFSR concludes:

“Cases were often continued or rescheduled, which caused significant delays in moving toward permanency. In New Mexico, adjudications are required within the first 60 days of a case. It was not uncommon for adjudications to be continued and rescheduled over a significant amount of time, resulting in adjudications happening at 9, 11, 16, 18, and 19 months. The issue of

¹³² NMDOJ interview with child psychiatrist Dr. George Davis (June 9, 2025).

¹³³ NMDOJ interview of B.R. (May 29, 2025).

continuances and rescheduled cases was also raised during [termination of parental rights (TPR)] hearings.”¹³⁴

Foster parents, legal practitioners, and former CYFD staff also report that time pressures and case backlogs often lead to misleading—and sometimes false—court filings and testimony by PPWs. Multiple individuals interviewed by the NMDOJ specifically identified one particular permanency supervisor as repeatedly providing false information to the Children’s Court. Misrepresentations by PPWs cover a wide range of issues, including facilitation of services, IEP participation, reunification efforts, parental compliance with treatment plans, and home visits. In one case, for example, a PPW told the court that the biological parents were actively engaged in their child’s early intervention services, though in reality they were often absent from appointments. In another instance, CYFD claimed a child had weekly visits with their grandfather, despite their grandfather having been deceased for months. Skewed or false information by PPWs undermines judicial decision-making and reduces trust in the permanency process and its outcomes.

Permanency setbacks are not solely the result of CYFD’s failures: the Children’s Court shares responsibility by allowing the Department’s chronic inefficiencies and substandard practices to persist unchecked.¹³⁵ While CYFD has been sanctioned for missing or untimely court reports, these penalties remain largely symbolic—courts rarely issue orders to show cause, hold the Department in contempt, or require the cabinet secretary’s appearance. Effective deterrence demands more than nominal sanctions; it requires meaningful consequences and rigorous enforcement that compels institutional reform. Although state law permits media access to abuse and neglect proceedings,¹³⁶ courts frequently impose restrictive conditions or sealing orders that undermine the intent of transparency. Allowing media and other stakeholders to observe—subject only to essential confidentiality safeguards—would strengthen oversight, promote accountability, and serve as a critical check against unsupported judicial decisions and Department misconduct.

¹³⁴ CFSR 2025 New Mexico Final Report at 7.

¹³⁵ *Id.* (“[M]ore often the court left the direction of the case to the agency. The court was not directing necessary action that would serve to move the case forward.”).

¹³⁶ NMSA 1978, § 32A-4-20.

Timely permanency decisions are further hindered by CYFD's failure to adhere to federal and state law governing the filing of TPR motions. TPR laws are designed to expedite permanency decisions, requiring CYFD to file for termination of parental rights when a child has spent 15 of the past 22 months in foster care, unless specific

exceptions apply.¹³⁷ These deadlines are routinely ignored. Foster parents describe children lingering in state custody while biological parents repeatedly ignore treatment and parenting plans, creating prolonged instability and uncertainty for these children. The 2025 CFSR

Pending Motions for the Termination of Parental Rights

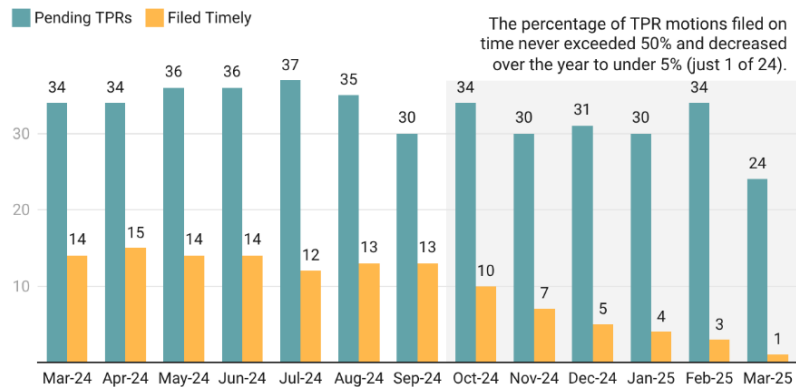


Figure 7. Number of total pending termination of parental rights motions, including those filed timely, March 2024-March 2025. Reproduced from CYFD's March 2025 Data Evaluation Unit report.

Children with a Plan of Adoption

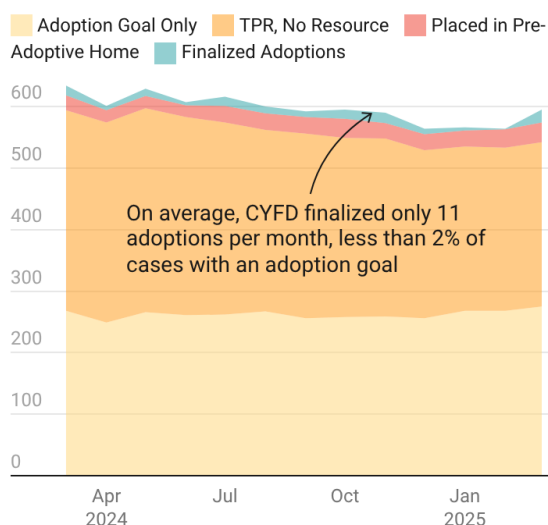


Figure 8. Stage of cases with a permanency plan of adoption, March 2024-March 2025. Reproduced from CYFD's March 2025 Data Evaluation Unit report.

confirmed that “data and information received did not demonstrate that [TPR] petitions were routinely filed in a timely manner in accordance with federal requirements.”¹³⁸ CYFD's own metrics show that even in its best month, fewer than half of TPR motions were filed on time¹³⁹—and former staff report that many cases had no motion filed at all.

Even after parental rights are terminated, CYFD regularly delays the full disclosure process¹⁴⁰ and adoption finalization. The CFSR authors indicated that “achieving adoption finalization appeared challenging in the cases observed.”¹⁴¹ Former CYFD supervisors report that slow

¹³⁷ NMSA 1978, § 32A-4-29(G); 42 U.S.C. § 675(5)(E).

¹³⁸ CFSR 2025 New Mexico Final Report at 17.

¹³⁹ CYFD March 2025 Report at 5.

¹⁴⁰ NMSA 1978, § 32A-5-3(Q). Full disclosure is defined as “mandatory disclosure by CYFD of information about an adoptee,” including health, psychological, genetic, social, placement, and education history.

¹⁴¹ CFSR 2025 New Mexico Final Report at 4.

TPRs—combined with adoption backlogs and a shortage of attorneys—inflate caseloads and prevent children from achieving timely permanency. Multiple prospective adoptive parents illustrate the depth of the problem: families waiting years for full disclosure documents, repeated attempts to complete paperwork without success, and lost records that stall the process. Despite hundreds of cases with permanency plans of adoption, CYFD finalized an average of only 11 adoptions per month over the latest reporting period.¹⁴²

The NMDOJ’s concerns about CYFD’s handling of permanency planning isn’t merely about efficiency—it’s about the need to prioritize and safeguard children. Extended proceedings, inaccurate reports and testimony, delayed TPR’s, and prolonged adoptions leave children without the stability and enduring family relationships that CYFD’s permanency unit was created to deliver.

B. Systemic Failure: Missed Removals & Premature Reunifications

Rates of child maltreatment—including physical, emotional, and psychological abuse; abandonment; neglect; and sexual exploitation—remain alarmingly high in New Mexico. According to the LFC, 12.6 out of every 1,000 children in the state experienced maltreatment in 2023, over 40% above the national average of 7.4 per 1,000.¹⁴³

The long-term consequences of child maltreatment are profound, resulting in lasting physical and psychological trauma on children and placing significant financial burden on the state’s child welfare infrastructure, behavioral health services, and broader medical care systems.¹⁴⁴

After a lengthy investigation, the NMDOJ concludes that CYFD’s failures to make timely and common-sense decisions that prioritize child safety has been a central driver of New Mexico’s child maltreatment crisis. In many cases, CYFD’s chronic inaction has led to extended delays in removing children from dangerous environments, or not removing them at all. In some cases where CYFD took children into temporary custody, the Department often contributed to the child’s revictimization by prematurely reunifying them¹⁴⁵ with parents before their safety and stability is assured.

¹⁴² CYFD March 2025 Report at 2.

¹⁴³ LFC Report on Child Maltreatment at 1.

¹⁴⁴ Legislative Finance Committee, [Performance Report Card for CYFD, Second Quarter, Fiscal Year 2024](#) 1 (March 2024).

¹⁴⁵ This issue is likely to intensify as reunifications make up a growing share of permanency outcomes. According to the Kevin S. 2023 Co-Neutrals’ Annual Report, reunifications rose by 11% between 2021 and 2023—now comprising 56% of all permanency goals—while adoptions declined by 12%, accounting for just 30%. Judith Meltzer and Kevin Ryan, [Co-Neutrals 2023 Annual Report: Kevin S., et al. v. Blalock and Scrase](#) 23, Center for the Study of Social Policy (Nov. 15, 2024).

The impact of CYFD’s systemic failures is evident in New Mexico’s persistently high rate of *repeat* maltreatment, which ranks among the top six states for recurrence within 12 months of an initial report.¹⁴⁶ The rate of repeat child maltreatment rose to 15% in FY 2024—higher than the national benchmark of 9%.¹⁴⁷ If New Mexico had the same rate of repeat maltreatment as the national average, roughly 360 fewer cases would occur annually.¹⁴⁸ The consequences of CYFD’s institutional breakdowns can be seen clearly in New Mexico’s child fatality rate, which is highest among all western states.¹⁴⁹

The federal CFSR report confirms these troubling trends, concluding that New Mexico was out of compliance with key safety outcomes. Notably, CFSR found that New Mexico’s repeat child maltreatment rates are even more elevated in Bernalillo County and Doña Ana County, New Mexico’s two most populated counties:

“Bernalillo County and Doña Ana County account for 24.8% and 16.7%, respectively, of the initial victims in New Mexico. Additionally, Bernalillo County and Doña Ana County account for 27.5% and 19.2%, respectively, of recurring victimizations, indicating that these two counties have recurrence frequencies that are disproportionately high.”¹⁵⁰

In cases reviewed by the NMDOJ, CYFD has demonstrated a strong commitment to its family preservation goals. Indeed, state law requires the Department to make reasonable efforts to prevent the removal of children from their homes and to “preserve and reunify” families whenever possible. Federal and state law are clear, however, that when preservation of reunification conflicts with a child’s safety, the child’s well-being takes precedence.¹⁵¹

Children Subject to Repeat Maltreatment Within 12 Months

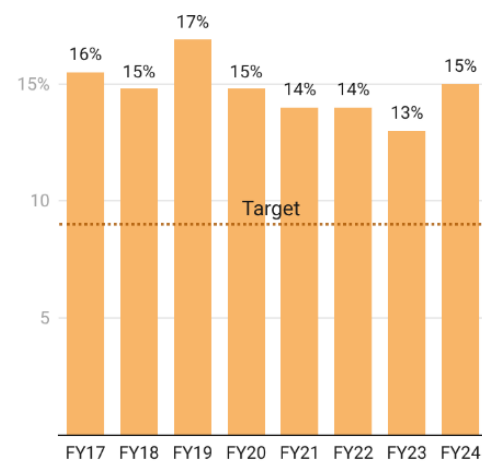


Figure 9. Children subject to *repeat* maltreatment, FY’17-FY’24. Reproduced from LFC’s presentation to House Approp. & Finance Committee (February 12, 2025).

¹⁴⁶ Legislative Finance Committee, [Appropriations Recommendations: January 2025 for the 2026 Fiscal Year](#) 350 (Jan. 2025).

¹⁴⁷ *Id.* at 348. CYFD reported the repeat maltreatment rate improved slightly to 14% in the third quarter of FY 2025. LFC Report on Child Maltreatment at 1.

¹⁴⁸ LFC Report on Child Maltreatment at 1.

¹⁴⁹ U.S. Admin. on Children, Youth and Families, [Child Maltreatment 2023](#) 63 (Table 4-1) (Jan. 8, 2025).

¹⁵⁰ *Id.* at 9.

¹⁵¹ New Mexico’s Supreme Court and Court of Appeals have long recognized that while parents possess a natural and legal right to the custody of their children, that right is not absolute and must yield to the best

CYFD’s longstanding emphasis on family preservation at nearly any cost reflects a fundamental perversion of its mission.

The following Abuse and Neglect Act¹⁵² excerpts illustrate how CYFD is expected to balance family preservation or reunification with child safety:

Table 4. Statutes from New Mexico Children's Code prioritizing a child's health and safety.

Statutory Provision	CYFD’s Legal Duty
§ 32A-1-3(A) (emphasis added in each section)	“The Children’s Code shall be interpreted and construed to effectuate the following legislative purpose: first to provide for the care, protection and wholesome mental and physical development of children coming within the provisions of the Children’s Code and then to preserve the unity of the family whenever possible. <i>A child’s health and safety shall be the paramount concern.</i> ” ¹⁵³
§ 32A-4-7(D)	“Reasonable efforts shall be made to prevent or eliminate the need for removing the child from the child’s home, with <i>the paramount concern being the child’s health and safety.</i> ”
§ 32A-4-18(E)	Related to initial custody hearings: “Reasonable efforts shall be made to preserve and reunify the family, with <i>the paramount concern being the child’s health and safety.</i> ”
§ 32A-4-22(C)	“If a child is found to be neglected or abused, in its dispositional judgment the court shall also order the department to implement, and the child’s parent, guardian or custodian to cooperate with, any case plan approved by the court. Reasonable efforts shall be made to preserve and reunify the family, with <i>the paramount concern being the child’s health and safety.</i> ”
§ 32A-4-25(H)(5)	After a judicial review hearing, the court may: “. . . continue the child in the legal custody of the department with or without any required parental involvement in a treatment plan; provided that reasonable efforts shall be made to preserve and reunify the family, with <i>the paramount concern being the child’s health and safety</i> unless the court finds that such efforts are not required.”

interests and welfare of the child. *E.g., Roberts v. Staples*, 1968-NMSC-109, ¶ 20, 79 N.M. 298; *In re Samantha D.*, 1987-NMCA-082, ¶ 11, 106 N.M. 184.

¹⁵² See NMSA 1978, §§ 32A-4-1 to -35 (Abuse and Neglect Act).

¹⁵³ This requirement stems from federal law. The Adoption and Safe Families Act (ASFA) of 1997, 42 U.S.C. § 671(a), provides that in order for states to be eligible for federal payments, they must have a plan for foster care and adoption assistance, which provides that reasonable efforts be made to preserve and reunify families, but *that the child’s health and safety shall be the paramount concern.*

CYFD's regulations also require it to prioritize child safety. Specifically, CYFD regulations require it to use a "best interest of the child" standard when planning and managing child protective services cases. The regulations emphasize that "protection and the best interest of the child are of paramount concern, followed by the treatment needs of the family."¹⁵⁴

OVERARCHING PRINCIPLES:

5.1 Safety of the Child: The safety of the child is the overriding concern throughout the casework relationship with the family. If the safety of the child is ever in conflict with the preservation of the family unit, the child's need for protection takes precedence. [05-10-2010]

CYFD's investigative and permanency planning protocols mirror the obligations described in statutes and regulations. Investigation policies state plainly that child safety should always be the top priority.¹⁵⁵

5 SAFETY ASSESSMENT IN PERMANENCY PLANNING: When a parent, guardian or custodian cannot mitigate safety threats to the child and the child is deemed unsafe, an out of home placement is the initial intervention used to keep the child safe. The overriding concern throughout the life of a permanency planning case is the safety of the child.

After CYFD assumes custody of a child, subsequent permanency decisions must also prioritize the child's welfare. CYFD is required to make reasonable efforts to preserve and unify the child with his or her biological family, with the paramount concern being the child's safety, health, and well-being.¹⁵⁶ In making assessments about parental suitability and family reunification, the "overriding concern" for PPWs must be the safety of the child.¹⁵⁷

The following case studies present true accounts of children and families who have interacted with CYFD. To ensure the privacy of those involved, pseudonyms are used throughout. These cases demonstrate that CYFD's actions often do not align with its legal duty to protect children. They reveal deep-rooted problems that CYFD must address to protect children and reduce maltreatment across New Mexico.

1. Case Study: "Sarah M."

Leo M. was born on January 17, 2015, to Sarah M.—a 17-year-old in CYFD custody. Since taking Sarah into state custody at age 11, CYFD knew she carried an extensive history of mental illness and sexual abuse. The Department was also aware that Sarah's parental

¹⁵⁴ 8.10.7.10(B) NMAC.

¹⁵⁵ CYFD Invest. Proc. PR 10, § 5.1 ("Overarching Principles: Safety of the Child"); see also 8.10.3.10(A) NMAC.

¹⁵⁶ CYFD Invest. Proc. PR 14, § 7 ("Reasonable Efforts").

¹⁵⁷ CYFD Invest. Proc. PR 9, § 5 ("Safety Assessment in Permanency Planning"); see also 8.10.8.9(A) NMAC.

rights to her first child had been terminated only one year prior to Leo's birth. As Sarah's legal guardian, CYFD was aware of Sarah's pregnancy but ignored the many warning signs that she was unprepared to parent. CYFD made no concrete plan for Leo's safety, and ultimately left a defenseless infant in the care of a minor still grappling with complex emotional and psychological challenges. From the moment Leo was born, his safety depended on CYFD's protection. However, the Department repeatedly failed to sufficiently intervene—despite numerous abuse and neglect reports and notice of clearly inadequate safety plans—leaving Leo in danger throughout his short life. CYFD's failures lead to Leo's untimely death.

a. CYFD failed to protect Leo M. despite twelve (12) credible reports of abuse and severe neglect.

One day after Leo's birth, hospital staff reported to CYFD that Sarah was not adequately supervising Leo and showed signs of emotional detachment. Rather than recognizing this as an immediate risk, CYFD accepted Sarah's assurance that she would rely on her mother for help in caring for Leo. It should have been obvious that Sarah's mother would not serve as an adequate support system—she had 22 prior abuse and neglect reports made against her, causing her to lose her own parental rights to Sarah.¹⁵⁸

CYFD deemed the hospital staff's report unsubstantiated, ignoring the fact that both adults responsible for Leo posed serious and well-documented risks to his safety. Although Sarah was advised to complete parenting classes and seek other services, she never followed through, and CYFD failed to enforce compliance or reassess risk to Leo.

On March 15, 2015, a report was made to CYFD alleging that Leo was being medically neglected. The reporter noted that Sarah was sleeping most of the day while her mother assumed primary responsibility for Leo's care, and that Sarah failed to seek medical attention for Leo despite recurring illnesses. CYFD declined to substantiate the report, instead recommending that Sarah voluntarily seek a behavioral health assessment and services through PB&J Family Services. CYFD's response was insufficient, and Leo remained with the same unfit caregivers.

By August 2015, the reports of neglect became more severe. On August 7, 2015, CYFD learned that Sarah routinely left Leo unattended, sometimes isolating herself in her room or leaving the home entirely. CYFD's home visit revealed filthy conditions—including trash, spoiled food, cockroaches, and pet feces throughout the residence. A Family Centered Meeting (FCM) facilitated by the Department identified serious safety threats, including Sarah's mental health issues, lack of supervision, and an unsafe home environment. Despite

¹⁵⁸ Sarah's mother was reported to CYFD for physical abuse, neglect, excessive discipline, and educational neglect of Sarah.

acknowledging these dangers, CYFD refused to take custody of Leo and instead created a voluntary safety plan that placed him under the watch of Sarah's sister as a temporary safety monitor.

The safety plan provided that CYFD would ensure the family receive: (1) co-parenting counseling, (2) a mental health assessment and infant mental health early intervention, (3) housing support, (4) "life skills" resources, and (5) case management services. However, CYFD violated its own policy by closing the investigation while the safety plan remained active, and without confirming that the dangerous circumstances had been resolved.

Within weeks, multiple violations occurred, including missed case management meetings and appointments with CYFD personnel, refused counseling services, and a home that quickly returned to squalor. Even as the plan fell apart, CYFD failed to consider filing for legal custody of Leo, continuing his exposure to a harmful home environment.

On April 4, 2016, a new report was made alleging that Sarah's mother neglected Leo. CYFD continued to treat these reports as isolated incidents, refusing to see the extensive pattern of documented danger. CYFD ignored the grandmother's history of abuse and neglect, including the loss of her own parental rights. The Department again deemed the allegations unsubstantiated and took no further action to protect Leo.

On February 12, 2018, Albuquerque Police Department (APD) officers were dispatched to Sarah M.'s apartment and found piles of trash, rotting food stuck to the floor, and debris that made it difficult to walk. Officers noted a strong stench of urine, animal feces scattered throughout the apartment, and several cages containing hamsters, guinea pigs, and ferrets—with bedding from their cages littering the floor. Hazardous chemicals—including bug spray and anti-freeze—were on the ground within reach of three-year-old Leo.



Figure 10. APD lapel video still frame on February 12, 2018, documenting unsanitary living conditions at Sarah M.'s apartment.

The APD police report describes how Leo was found:

"The bedroom [Leo] was in was secured by two dog gates stacked on top of each other approximately four feet high making it impossible for [Leo] to get

out of the room. There were no lights inside the bedroom. There was a racecar bed frame with no mattress and to the right of the bed frame was a twin size mattress with large stains and no sheets. The carpet floor had stains, there were stains on the walls, and the room had a strong odor of cat urine.”

CYFD’s [safety assessment](#) acknowledged that Sarah failed to put Leo’s needs first. The assessment revealed that the Department was fully aware of the many safety threats present in the home:

Safety Summary:

██████████ is conditionally safe. The home had numerous safety threats throughout: Dozens of potential choking hazards - including cat feces - that ██████████ could easily pick up. There were also chemical hazards left unsecured on the floor for ██████████ to access: Window washer fluid, liquid detergent, and arm and hammer products scattered throughout the home. There were also biological hazards in the fridgerator and in the kitchen sink: Moldy, and rotten food. ██████████ had also been penned in his room to allegedly “keep the cats from attacking him while he eats.” House was deemed unsafe, but no other abuse identified. Mother and son stayed at Econolodge while boyfriend cleaned the home. Grandmother would watch ██████████ while the mother was at work. Follow up will occur in the next 24 hours.

APD properly treated the threat to Leo as a serious emergency, filing criminal charges against Sarah for child cruelty. CYFD failed to show the same urgency or commitment to Leo’s safety. While CYFD instructed that the apartment be cleaned, it did not take meaningful action to ensure Leo’s well-being.

On May 23, 2019, Sarah’s then-boyfriend, Dante V., dropped four-year-old Leo off without warning at the home of Sarah’s half-sister and stepfather. Leo was in poor physical condition, with severe diaper rash and dental problems. By June 6, 2019, Sarah’s half-sister and stepfather reported to both APD and CYFD that Sarah had neither checked on Leo nor provided them any financial support or personal items for his care. APD also documented multiple injuries to Leo, including lacerations, bruises, and abrasions on his back, thigh, chest, finger, and foot, as well as facial injuries.

In an APD [lapel video](#), Leo disclosed that Dante inflicted these injuries, and would hit him with a hanger and a hairbrush. Leo said that he told his mother, but she did “nothing.” Officers confronted Sarah about these clear signs of abuse. She admitted that Dante spanked Leo on multiple occasions and that she would have to pull Dante away from Leo. Sarah told police that she did not report the abuse “due to her financial status and the high level of stress she had been dealing with.”

CYFD acknowledged that Leo was unsafe with his mother. Investigators agreed with APD’s assessment that he should not be under Sarah’s care—reinforcing the credibility of Leo’s abuse disclosures and noting, [“you don’t make that up at four.”](#) In speaking with Sarah, CYFD identified her imminent eviction and unstable housing as barriers to providing proper

care for Leo. Sarah's apartment was in disarray—mirroring the conditions documented in both August 2015 and February 2018—with broken glass on the floor, overflowing trash, and filthy bedrooms.

CYFD conducted a substandard investigation. CYFD's flawed use of its safety and risk assessment tools led to an inaccurately low risk rating for Leo. Investigators failed to consider critical facts—such as Sarah exposing Leo to an abusive partner—and CYFD neglected to conduct key interviews. Once again, APD took decisive action—charging Dante with battery for abusing Leo. In contrast, although CYFD substantiated the abuse this time, it still failed to seek Leo's removal or implement any meaningful protections, leaving him exposed to a worsening situation.

On June 22, 2019, Sarah's half-sister called APD after Sarah showed up unannounced and took Leo from the home. The half-sister expressed concern for Leo's safety, citing past abuse allegations and Sarah's inadequate housing. Sarah confirmed to CYFD that she would be staying with her new boyfriend, Esteban A., in Rio Rancho. CYFD's investigator told law enforcement she did not believe Leo was at risk with Sarah—only with her ex-boyfriend, Dante. That conclusion defied history and logic: just weeks earlier, Sarah had admitted to knowing about Dante's abuse of Leo and failing to report it. Even if Dante were the primary threat, there was no way to ensure Sarah would not resume contact with him. CYFD also had no knowledge of Sarah's current boyfriend and his living situation. Despite these risks, CYFD chose not to implement a safety plan or seek Leo's removal. Everyone other than CYFD seemed to recognize that Leo would be in danger in his mother's care. Sarah's family summed up CYFD's approach toward Leo's safety:

[“The state is going to smack her hand and hand him back, and then God knows what's going to happen to him, and you know what, it's going to be a bigger problem.”](#)

In September 2019, CYFD received four separate neglect referrals concerning Leo within a 10-day span. On September 10, 2019, CYFD received a report alleging that Sarah was neglecting Leo by leaving him unsupervised with unsafe roommates. The next day, CYFD received another report revealing that Leo had been found alone outside the apartment complex. Sarah admitted she had left him with a friend, who left Leo unattended. Sarah also acknowledged that Leo could let himself out of the apartment and wander off. CYFD's only response was to advise Sarah to install a sliding lock on the door. Further, although the referral raised concerns about possible drug use, Sarah refused CYFD's request to submit to drug testing. CYFD's superficial recommendations and indifference to Sarah's potential drug abuse reflected its ongoing disregard for Leo's safety. The Department remained unwilling to take action in the face of clear and escalating risk.

On September 14, 2019, CYFD received another report stating that Sarah was not feeding Leo, after he had been seen wandering the apartment complex—which notably was an area known for drug use and gang violence—looking for food. According to a [CPS Intake Report](#), when Rio Rancho Police arrived to Sarah’s apartment, Leo appeared malnourished and dirty. CYFD was also informed that Sarah was using her paycheck to buy alcohol to drink with friends at the apartment. A CYFD supervisor documented multiple risks to Leo’s safety in their intake report:

CPS Intake Report

Supervisor Narration :

Concern for lack of supervision, inadequate food and endangerment due to child often wandering around complex alone, mother's drug and alcohol use, having other adults in with whom mother uses drugs with while child is in the home, and child often asking neighbors for food because mother does not feed him. AB

Cross Report- Rio Rancho PD

On September 18, 2019, law enforcement notified CYFD after finding Leo alone under a stairwell, clutching two teddy bears. He had been unsupervised for nearly thirty minutes before his mother appeared. The next day, a CYFD investigator visited the home, briefly observed Leo, and concluded that he appeared safe because he was dressed appropriately. Despite the recurring instances of Sarah’s outright abandonment of Leo, CYFD unsubstantiated each report. Rather than impose a safety plan, seek court-ordered services, or initial removal proceedings, CYFD dismissed these warning signs and allowed Leo to remain in jeopardy.

In late September 2019, Sarah and Leo moved in with Sarah’s friend, Erica C., Erica’s boyfriend, Marcus P., and their two children. CYFD unsuccessfully attempted home visits at this new location. Considering Sarah’s history of exposing Leo to abusive or neglectful caregivers, these failed visits should have prompted heightened concern and rigorous follow-up to ensure Leo’s safety. Instead, CYFD made no further effort to assess the new living arrangement for potential risks.

It took less than a month after Sarah and Leo moved in with Erica and Marcus for Leo to resurface on CYFD’s radar. On October 18, 2019, Leo was brought to Duke City Urgent Care with multiple injuries indicating physical abuse. APD’s crime scene investigator documented the severity of Leo’s physical condition:

Crime scene investigator, L. Laskar (6484) arrived and photographed all of [REDACTED] injuries at Duke City Urgent Care. [REDACTED] had redness and bruising to his left eye, a scratch between his eyes on the bridge of his nose, a scratch on his right hairline, a scab on the front of his neck, a scratch on the back of his neck along his hairline, a large scratch behind his left ear, bruising along his back, two small circular scabs on his back, a scratch above his buttox, a small circular bruise on his left butt cheek, a small circular scab on the back of his left leg, a scratch along his left side, a scab on his left knee, bruising to his right shins and a bruise to the right of his left knee, and purple and black bruising to his penis. [REDACTED] also had his left arm in a splint and a sling prior to officer’s arrival.

Officers interviewed Sarah, who stated that Leo injured his elbow while trying to jump out of a vehicle under Erica C.'s supervision. She claimed Erica grabbed his arm, causing it to pop out of place. Sarah also reported that the scratches on Leo were caused by Erica's two-year-old daughter, who had been playing roughly with him since they moved in. While denying any knowledge of sexual abuse, Sarah acknowledged seeing purple and black bruises on Leo's penis, which she attributed to a fall at the park about a month earlier.

APD consulted with Duke City's physician who observed three distinct bruises on Leo's penis, along with multiple other injuries in various stages of healing. During the examination, Leo disclosed that Sarah's boyfriend Esteban would shower with him and touch his penis. The physician also noted that the scratch behind Leo's ear and the bruises on his back were inconsistent with injuries that could be caused by a two-year-old playing rough with Leo. The physician's clinical diagnosis was non-specific penile bruising possibly caused by inflicted trauma and a history consistent with physical abuse.

A CYFD investigator interviewed both Leo and Sarah at Duke City Urgent Care. Leo disclosed that his mother's boyfriend had scratched his penis and body, and that he was hit on the buttocks and legs with a shoe and a brush when in trouble. He also reported that Erica and Marcus "hit him a long time," and that Marcus had stepped on and hit him the night before. Sarah confirmed that Marcus sometimes babysat Leo and disciplined him. The investigator also spoke with medical staff and observed the extent of Leo's injuries. During CYFD's interview with Erica, she confirmed that the Department was already investigating an abuse and neglect allegation involving another child in the home—an additional concern that should have prompted further scrutiny of the household's suitability for any child.

CYFD put Leo on a 5-day respite plan with another resource foster family while it evaluated Erica and Marcus's home for safety risks. During a home visit on October 21, 2019, CYFD's investigator observed trash piled up at the front of the residence and noted that the home was unclean and had an unpleasant odor. The condition of the home was so concerning that CYFD's investigator independently filed a new neglect report through SCI. This environment resembled the same unsafe, filthy conditions Sarah had exposed Leo to on three prior occasions.

On October 21, 2019, Leo underwent a medical evaluation by a sexual assault examiner, which was attended by the CYFD investigator. Leo disclosed that Erica had broken his arm, and that she, Marcus, and his mother hit him in the face and on the buttocks with a shoe when he was in trouble. Leo further disclosed that he gets hit with a brush on his penis. Two days later, Leo completed a forensic interview, with CYFD again present. There, he provided additional graphic details, stating that Marcus had repeatedly burned him with hot water and grabbed his penis, causing it to bleed. Leo also disclosed that Erica had hit him all

over his face and body. The CYFD investigator reported these disclosures from both the medical exam and forensic interview to her supervisors.

CYFD possessed overwhelming factual and legal justifications to remove Leo from Sarah's custody due to continuing and escalating abuse and neglect. However, CYFD's investigation was deeply flawed. The investigator incorrectly completed the safety assessment by failing to include multiple relevant danger indicators, most notably that Sarah was consistently unable or unwilling to protect Leo from serious harm perpetrated by others. CYFD also failed to update or override its safety assessment after Leo disclosed extensive abuse during his sexual assault examination and forensic interview. Notwithstanding these investigative deficiencies, CYFD's investigator recommended to her supervisors that Leo be immediately taken into state custody.¹⁵⁹ Instead of acting on this recommendation, the supervisor dismissed the investigator's concerns, instructing her to "calm down" and wait to address the matter at the Family Centered Meeting (FCM) scheduled the following day.

CYFD facilitated a [FCM](#) with Sarah on October 23, 2019. Erica—whom Leo had recently accused of physical abuse—was permitted to attend and participate in the meeting. At the FCM, the CYFD investigator urged Sarah not to return to Marcus and Erica's apartment with Leo. In fact, CYFD raised 11 separate concerns about Sarah's ability to care for Leo (right). These included recent incidents of physical abuse and injury, an unstable living environment, and exposure to unsafe individuals whom Sarah entrusted Leo's care. The investigator also cited prior involvement with law enforcement and child protective services, including Sarah's past failures to report known abuse of Leo to CYFD. The investigator warned her direct supervisor and county office manager that if released back to Sarah's custody, Leo would be in serious danger.

Concerns:

- Bruising on [REDACTED] penis that is severe.
- Bruising on [REDACTED] back & possibility legs.
- Unstable living circumstances.
- Lack of stable place for mom & [REDACTED]
- Individuals who care for [REDACTED] when mom is at work.
- Law Enforcement is involved with family.
- Prior Hx with the Department.
- Delay in mom reporting concerns to Dept.
- [REDACTED] stated several times that [REDACTED] hit him.
- [REDACTED] also stated that [REDACTED] has hit him & [REDACTED]
- Injuries are recent.

Despite clear warnings of continued abuse, the investigations supervisor and county office manager declined to take Leo into custody. Notably, the supervisor was not a licensed social worker and held no certification or professional designation relevant to his role. He later admitted he was unaware that Sarah had previously failed to comply with safety plans

¹⁵⁹ Per policy, CYFD investigators were required to obtain approval from investigations supervisors and participate in a legal staffing prior to filing an *ex parte* petition seeking Leo's removal.

established in earlier investigations. Despite lacking the qualifications or baseline knowledge to make sound decisions that could have protected Leo from future harm, the supervisor decided that Leo would be returned to Sarah's custody with a safety plan. The safety plan included seven conditions, including a requirement that Sarah reside at Joy Junction away from Erica and Marcus, and that she participate in counseling—something that she had consistently avoided for years. In the event that Leo became unsafe, Sarah agreed that she would contact law enforcement and CYFD.

Predictably, Sarah violated the safety plan the very next day by leaving Joy Junction, missing her scheduled appointment with CYFD, and initially failing to respond to phone calls or text messages. The CYFD investigator contacted the APD detective handling Leo's physical and sexual abuse case, and informed him that Sarah had left with Leo to Arizona to live with Sarah's aunt. When CYFD's investigator contacted Sarah's aunt, she was told that Sarah had never actually traveled to Arizona. Although CYFD knew Leo was at risk and his whereabouts were unknown, it made no meaningful effort to locate him. The APD detective interviewed Sarah's half-sister, who also lacked knowledge of Leo's whereabouts. Sarah's half-sister cautioned that “[Leo] [should have never been taken back into his mother's care.](#)”

b. CYFD's prolonged inaction culminated in Leo's death.

On December 10, 2019, APD and emergency responders were dispatched to Erica and Marcus's residence following a report that Leo was unconscious and not breathing.¹⁶⁰ Leo was transported to UNM Hospital in cardiac arrest, exhibiting signs of severe physical trauma. Leo was pronounced deceased at UNM Hospital, just over one month short of his fifth birthday.

APD's investigation revealed that Leo was left alone with Marcus after Erica and Sarah left the apartment. Marcus provided an implausible story to police, saying that he tripped and landed directly on Leo with his knee. He later stated that Leo fell on his own and hit his head on a stereo. Marcus and Erica's daughter disclosed to a CYFD investigator that she witnessed Marcus injure Leo.

The Office of the Medical Investigator's (OMI) [autopsy](#) determined that Leo's cause of death was blunt head and torso trauma. OMI reported multiple facial and scalp contusions, an acute right skull fracture, and hemorrhages in Leo's brain. Leo was also found to have several rib fractures and lacerations to his lungs, liver, and pancreas. Leo had both “healing” and “acute” injuries, indicating that he was brutally abused over the course of multiple

¹⁶⁰ Although CYFD was aware that Sarah had violated the safety plan and that Leo's whereabouts were unknown, Sarah and Leo continued living with Erica and Marcus—where they had resided for months. This location should have been reasonably foreseeable to CYFD.

months. The [OMI Body Chart](#) reveals the extent of physical abuse that Leo suffered. OMI's pathologist concluded that:

In summary, there were multiple acute blunt force injuries involving different parts of the body which were fatal. Healing jaw fractures and healing subdural hemorrhage indicates significant blunt head trauma that occurred at a time much earlier (weeks) than the acute injuries.

Sarah, Erica, and Marcus were each charged and pleaded guilty to child abuse in connection with Leo's death and served prison sentences.

c. CYFD supervisors attempted to conceal their failure to protect Leo.

Following Leo's death, CYFD took deliberate steps to obscure and downplay its decision to leave Leo in Sarah's custody. During related civil litigation, the primary CYFD investigator—who had previously pled with her supervisor for Leo to be taken into state custody—was deposed about these actions. She testified that, after Leo's death, her supervisor and county office manager instructed her to expedite completion of her notes. Normally, investigators enter their findings directly into CYFD's FACTS system without edits from supervisors. But this time, the investigator was instructed to draft her findings in a Word document to allow CYFD supervisors to review and edit her findings. Departing from standard protocol, the supervisor and county office manager instructed the investigator to redact certain parts of the report before it was uploaded to FACTS.

These post-hoc redactions and omissions were egregious. First, the assigned investigations supervisor and county office manager explicitly directed the investigator to remove references to her communications with law enforcement about efforts to remove Leo from Sarah's custody. The county office manager also directed the investigator to remove any mention that CYFD would seek an *ex parte* custody order if Leo could be located.

In the county office manager's deposition, she testified that CYFD lacked legal authority to remove Leo without a law enforcement hold. This testimony not only reflected a fundamental misstatement of the law but revealed an alarming ignorance of the basic legal tools and responsibilities expected of someone in her supervisory role. The county office manager's testimony was clearly contradicted by the investigator's testimony and extensive records of threats to Leo in the years prior to his death. The county office manager's testimony reflects CYFD's egregious efforts to avoid accountability for Leo's death.

The CYFD investigator also detailed multiple failures that led to Leo remaining in Sarah's custody. The investigator testified that:

- The FACTS system prevented her from reviewing all prior substantiated and unsubstantiated reports due to time limits on record accessibility;

- The safety assessment tool was too rigid to account for the circumstances of Leo's case, in which Sarah frequently left him unsupervised with another adult caregiver;
- The safety assessment evaluated only Sarah's caregiving capacity, and failed to adequately consider Erica or Marcus, who were Leo's primary caregivers during the last months of his life; and
- The investigations supervisor possessed the authority to override the safety assessment and remove Leo, but chose not to exercise it.

CYFD had countless opportunities—spanning years and recurring credible reports—to protect Leo, yet consistently chose inaction over intervention.

d. Child welfare experts concluded CYFD violated professional standards and ignored known risks to Leo.

As part of civil litigation concerning Leo's death, an experienced child welfare expert and professor of social work reviewed the case. He authored a report documenting CYFD's repeated failures to protect Leo from abuse and neglect. The expert emphasized that Leo endured ongoing mistreatment while in his mother's care, supported by physical evidence, caretaker confessions, child disclosures, and witness observations. Despite numerous referrals, CYFD failed to ensure Leo's safety or provide Sarah with services needed to improve her caregiving. Leo's life was marked by instability—frequent caregiver changes, unsafe living conditions, and Sarah's persistent housing and mental health challenges. The expert noted that Leo did not receive necessary assessments, and when services were recommended, Sarah often failed to follow through without consequence.

The expert further concluded that CYFD failed to meet basic standards of child welfare practice and investigative procedures. Over four years, multiple investigations offered opportunities to assess Leo's safety, yet CYFD failed to act. Despite having seven years of records concerning Sarah's mental health, behavioral history, and lack of support, CYFD did not consistently refer her to services or meaningfully intervene. Caseworkers relied too heavily on flawed safety and risk assessments, rather than applying professional judgment and common sense. Had the tools been used correctly after the October 2019 investigation, Leo would have been deemed unsafe. Instead, CYFD failed to take Leo's safety seriously by choosing not to seek custody—even when the law would have permitted CYFD to do so.

The expert emphasized that CYFD took deliberate steps to avoid removing Leo, and that CYFD had no professional or ethical justification for keeping him in Sarah's care. At every stage, capable and willing relatives were available to provide a safe placement, yet CYFD

prioritized family unity over Leo’s safety. The expert described this approach as a misapplication of child welfare principles, stating:

“CPS caseworkers’ belief in keeping every family together no matter the risk or actual findings of abuse demonstrated a gross lack of understanding of state and federal regulations as well as professional child welfare practices and professional judgment which allowed repeated cases of abuse and/or neglect of [Leo] at the hands of his mother, relatives and mother’s friends.”

The expert concluded that “the repeated departures from professional judgment in this case were stunning.” Among the experts’ conclusions:

- 5. CYFD’s philosophy of keeping families together was not supported by programs, the practice or expertise to understand that some families cannot be kept together and this was one family that staying together represented an impending danger to [REDACTED]. Legal custody would have afforded [REDACTED] protection from impending danger.**
- 6. The hiring of investigators without social work licenses violated the New Mexico Social Work Practice Act, thus failing to meet the minimum requirement of knowledge and practice necessary to protect [REDACTED].**
- 7. Given [REDACTED]’ age and the number of referrals to CYFD, CYFD’s actions and failures to act created an unreasonable and known risk of danger to [REDACTED]. CYFD through its employees acted recklessly in conscious disregard of these risks.**
- 8. CYFD’s actions and inactions represented shocking and gross departures from professional judgement and grossly failed to meet even the minimum standards of care in social work and child protective services.**
- 9. These failures to meet the minimum standards of care led to [REDACTED] injuries and ultimately his death.**

For a deeper understanding of child welfare policies and best practices, the NMDOJ frequently consulted with Dr. Melissa Moyer throughout this investigation. Dr. Moyer is a licensed social work practitioner, masters of social work program director at Eastern New Mexico University, and a former CYFD county office manager. Dr. Moyer [authored a report](#) outlining her expert opinions on several cases of interest to the NMDOJ.¹⁶¹

In Leo’s case, Dr. Moyer found that critical gaps in CYFD’s training and managerial oversight directly contributed to his death.¹⁶² Dr. Moyer highlighted CYFD’s failure to properly staff Leo’s abuse and neglect investigations. Although Department policy requires supervisory involvement at key stages—such as case opening and closure, and with the county office manager and a Children’s Court attorney with high-risk cases—there is no

¹⁶¹ Melissa Moyer, *Report for the New Mexico Department of Justice on CYFD* (Oct. 16, 2025) (hereinafter “Dr. Moyer CYFD Final Report”).

¹⁶² Dr. Moyer CYFD Final Report at 1–2.

record of such staffing in Leo's case. Proper staffing is essential for guiding investigators, exploring protective options, and ensuring child safety. Dr. Moyer also highlighted that investigators were unaware they had the authority to request emergency *ex parte* custody, even amid clear safety concerns. This misunderstanding, combined with the failure to persist in locating Leo, reflects a lack both proper supervision and substantive knowledge.

Leo's life was characterized by recurring abuse, neglect, and instability. CYFD had multiple opportunities to interrupt that cycle. Instead, it enabled Leo's continued suffering by failing to intervene. CYFD's failures contributed to Leo's preventable and tragic death.

2. Case Study: "Amelia S."

In May 2022, Elena S.—a nonverbal, blind and developmentally delayed 16-year-old girl—died of malnutrition and dehydration due to severe neglect at the hands of her mother, Amelia S. Elena was the oldest of Amelia's five children. At the time of her death, Elena had two sisters (aged 13 and 14) and two brothers (aged 3 and 11), each with a different biological father. Elena was entirely dependent on Amelia for her survival. Amelia regularly failed to supervise Elena, subjecting her to hazardous living conditions and medical neglect. CYFD had clear and repeated notice of these ongoing issues, having conducted seven separate investigations into allegations of abuse and neglect between 2015 and 2020. CYFD failed to provide necessary services to Amelia and her family as required by policy, reached unsupported investigative decisions, and routinely closed investigations past deadlines and without proper supervisory oversight.

a. Seven abuse and neglect investigations in under five years made the risks to Elena unmistakably clear to CYFD.

The first abuse and neglect complaint against Amelia S. was made on September 2, 2015, alleging that Amelia would "go out a lot and leave the children alone." CYFD timely initiated its investigation. The investigator spoke with the affected children and Amelia, completed a home visit, discussed the issue with her supervisor, and encouraged the family to obtain dentists and primary care physicians for the children. CYFD deemed the complaint unsubstantiated after the children and Amelia denied the allegations and no further contradictory information could be obtained. This initial CYFD investigation would prove to be the only one carried out in accordance with CYFD's established policies.

On April 22, 2016, a nurse at Atrisco Elementary School made a [CPS report](#) to CYFD that Amelia's three daughters consistently attended school with dirty clothes and a strong odor. The referral noted that the smell was often so pungent that the girls would have to be sent to the nurse. The school provided clean clothes, but were running out of such supplies and sought CYFD's assistance. CYFD notes indicate that the family was provided clothes,

and a referral for additional services was made to Southwest Family Guidance. While an investigator completed a safety assessment on May 3, 2016, another safety assessment was not conducted and documented within 14 days of case closure, according to the Department's investigations policy.¹⁶³ Records of this investigation are inconsistent as to whether the allegation of "inadequate clothing" was ultimately substantiated. CYFD's investigation summary dated July 13, 2016, classified the allegations as substantiated. However, a separate notice of investigation sent to Amelia shows the investigation decision as unsubstantiated. Inconsistent records can lead to confusion by caregivers, and misinterpretation by future CYFD staff, resulting in delayed or inappropriate interventions.

A third report, this time alleging educational neglect by Amelia against her four children, was made to CYFD on September 6, 2017. Amelia initially stated falsely that her children were not in school due to lice but later acknowledged that she was unaware of what schools they should be attending. Investigation notes indicate superficial interviews, as the discussion with the two verbal children took a combined three minutes. Nonetheless, the allegations were substantiated on October 13, 2017. CYFD assisted Amelia in identifying the appropriate schools for enrollment.¹⁶⁴

On October 3 and 4, 2018, the [APD responded](#) to Amelia's residence following reports that her children, including nine-year-old Elena, had been left alone in filthy living quarters. A pest control technician and property manager who entered the apartment observed three children left unsupervised. Prior to law enforcement's arrival, the children were seen by neighbors walking through the parking lot after leaving the apartment. APD officers observed appalling conditions when conducting a walkthrough, documenting the following in their report:

As I opened the door numerous bugs started moving from the kitchen area and the entire apartment smelled of a foul odor. I could see stains on the carpet all over the apartment and numerous bugs all over the apartment. The bugs appeared to be small or big cockroaches. The bugs again were everywhere and I did not observe a lot of furniture inside the apartment. I also did not observe food inside the apartment. The apartment was not suitable for a child to be living in at this time.

The APD officer made a neglect report to CYFD through SCI due to the apparent lack of supervision, insufficient food, and inadequate shelter. SCI accepted the allegations for investigation and classified this as an "Emergency" case, requiring prompt face-to-face contact. CYFD's investigator did not contact the children until October 10, 2018, in breach of Department policy.¹⁶⁵ This untimely case initiation reflected a broader history of poor case

¹⁶³ CYFD Invest. Proc. PR 10, § 9.5 (stating that, a safety assessment must be completed and documented within 14 days prior to closure).

¹⁶⁴ After Elena's death, CYFD learned that her other children had also missed extensive school—one child 59 days, another 62.5 days—often for implausible reasons according to school personnel.

¹⁶⁵ An investigation is considered initiated when an investigator makes face-to-face contact with and assessed the alleged child victim. An emergency report requires an investigation be initiated within three hours of SCI screening decision. See CYFD Invest. Pro. PR 10, § 7.1 ("Time Frames for Initiation").

management by the assigned investigator. Less than three months earlier, the case manager had been suspended and demoted due to her role in a separate case where CYFD failed to act on 47 reports of abuse and neglect over 14 years, resulting in the sex trafficking and abuse of two young children. This employee would now be responsible for ensuring the protection of Elena and her siblings.

In response to the October 2018 incident, Amelia explained to CYFD that she was at the hospital giving birth to her son. While this hospital stay was confirmed, it did not account for her children being left without another caregiver, nor did it address the hazardous home environment. Further, CYFD's investigator inaccurately filled out the required safety assessment tool, failing to note that leaving a nonverbal and blind child in the care of her siblings for any period of time risks serious harm. CYFD referred Amelia to early intervention services—which are services reserved for children ages zero through three. While these services may have been helpful for Amelia's newborn, the program offered no support for her older, equally dependent children.

Although an apartment manager, pest control technician, and neighbor all reported that Amelia's children were left alone, CYFD dismissed the allegation of inadequate supervision. Likewise, and despite APD's observations of the apartment's untenable condition, the allegations of inadequate food and shelter were also unsubstantiated. CYFD made this determination without interviewing any of these witnesses with first-hand knowledge.

Six months later, on July 2, 2019, law enforcement was again dispatched to Amelia's residence after 12-year-old Elena experienced a medical emergency. Elena was unresponsive and not breathing, and Amelia's partner, Emilio E., resuscitated her while police and paramedics were en route. Once again, officers discovered [appalling conditions in the room](#) where the episode occurred:

as [REDACTED]. I then asked to see the room that [REDACTED] was in when she had her medical episode. I was then shown to the bedroom closest to the living room. I noted that there was a heavy urine smell emitting from the room. There were small cockroaches on the floor, on the clothes on the floor and on the mattress on the floor. The mattress was soiled and there was a puddle of dried feces on top where [REDACTED] was said to have been laying down. I saw a blanket with dry feces in the closet and a dirty diaper on the floor. I had

Officers also reported that there was insufficient food in the home, and that two of the bedrooms occupied by the children were missing beds. APD made a SCI report to CYFD. A [CPS Intake Report](#) documented the well-founded concerns of law enforcement: "Officer requesting worker to assess safety of the children in the home. Concerns [b]ased upon the age and development of the child, the home is hazardous to the safety a child(ren) and such conditions could lead to injury or illness of the child if not resolved."

Both Amelia and Emilio were criminally charged with negligently depriving the children of necessary food, clothing, or shelter.¹⁶⁶ Elena was hospitalized at University of New Mexico Hospital (UNMH) for nine days after being diagnosed as severely malnourished. Medical providers conveyed significant concerns about her nutrition and lack of consistent medical care. CYFD observed Elena in the pediatric emergency room, and described her as “very small in stature, very thin and does not talk.” Elena’s siblings stayed with Amelia’s sister for 24-hours while the home was cleaned. Although CYFD later assessed the home to be sufficiently clean, records show no follow-up visits, despite an emerging pattern of uninhabitable living conditions dating back to the October 2018 report.

CYFD’s July 2019 investigation also included a [flawed safety assessment](#). Among other errors, the investigator failed to recognize that a nonverbal, blind, special needs child laying on the ground surrounded by bugs and dried feces constituted physical living conditions that were “hazardous and imminently threatening to the child’s health and/or safety.”¹⁶⁷ CYFD substantiated the neglect report, but noted that the “family required no additional services.” Although no further investigation or service referrals followed, the case remained open in CYFD’s system until May 2020, in violation of policy.

On September 27, 2019, CYFD received a sixth report that Amelia was neglecting Elena. A social worker at UNMH reported that Elena had missed multiple appointments and that Amelia had failed to pick up her prescription medication. Such care is critical for typical adolescent development but was especially important given Elena’s complex needs. Elena’s missed appointments included occupational therapy, endocrinology, and primary care, and the report noted that a failure to monitor Elena’s prescriptions could become “life threatening.” CYFD investigators spoke with Elena’s caregivers. Amelia advised that the appointments were “set a long time ago” and Emilio was not telling her about the appointment reminder calls. Emilio stated he had been working a lot and forgot to tell Amelia about the appointments or pick up the medication.

During the investigation, CYFD again completed an inaccurate safety assessment and deemed Elena “safe.” CYFD reviewed the report in isolation and failed to consider the full history of Elena’s maltreatment and physicians’ warnings within the broader context of similar concerns raised during Elena’s hospitalization less than three months earlier. A closure staffing with a supervisor did not occur until June 17, 2020—or 219 days past the required deadline. No updated safety assessment was completed prior to case closure. CYFD again unsubstantiated the report and stated that the “family required no additional services.” The investigation summary noted:

¹⁶⁶ On September 12, 2022, a Metropolitan Court judge found Amelia guilty of this charge.

¹⁶⁷ Questions answered incorrectly in the [safety assessment](#) include #3, #4, and #9.

Disposition

On 6/17/2020 at approximately 11:30 am, based on the interviews of the parents, alleged victims, collateral contacts and worker observation, the allegations of PN/medical neglect is unsubstantiated on [REDACTED] based on lack of evidence. The safety assessment is safe. There are no danger indicators identified that places the child in immediate or impending danger of serious harm. The risk is high. [REDACTED] and [REDACTED] have protective capacities to offset, mitigate and/or control the indicators identified. The child will remain in the care of his parents at this time. No additional services needed at this time. This case will be sent for closure

On January 31, 2020, personnel at John Adams Middle School reported to CYFD that Elena smelled of urine over the past two weeks. While changing Elena's diaper, a classroom assistant noticed dried feces on Elena's lower back and thighs. CYFD performed an assessment, which indicated that Elena was safe in her environment, but that there was a "high" likelihood of future neglect. CYFD deemed the report unsubstantiated and closed the report, again without offering the family any resources or service referrals.

b. Elena's death was a foreseeable outcome given Amelia's history.

By failing to offer any meaningful support after seven reports of Amelia's neglect, CYFD all but ensured an eighth report would follow. That report came on May 3, 2022, when Elena suffered fatal neglect by her mother. On that day, Amelia took Elena—unresponsive and in full cardiac arrest—to UNMH, where doctors pronounced her deceased shortly after arrival. Bernalillo County Sheriff's Office (BCSO) deputies responded to the hospital and observed that Elena was extremely emaciated, with scrapes across her body, pressure sores on her hips and ankles, and maggots around her genitals.

During a [search of Amelia's home](#), crime scene investigators described the home as being in disarray, similar to the conditions CYFD had documented in October 2018 and July 2019. Law enforcement noted a refrigerator with rotten and moldy food, sitting water in the bathtub, and dog feces and flies throughout the home. In [Elena's room](#), BCSO reported observing a large stain on the bed that was "yellow in color with long black hair and what appeared to be feces in it . . . [T]here was also maggots in the blanket that was pulled back from the bed."

Sheriff's detectives interviewed Amelia, who admitted she hadn't changed, fed, or cared for Elena in a week. Amelia stated that she asked Elena's 14-year-old sister Naomi S. to feed and change Elena, and believed it was being done. In a forensic interview, Naomi confirmed caring for Elena and expressed feeling responsible for her death. An [OMI autopsy](#) concluded that the cause of death was malnutrition and dehydration from insufficient food and fluid consumption caused by prolonged neglect. OMI investigators confirmed that Elena's rashes were insect bites and that maggots had been present for at least four days. OMI further noted that laboratory tests indicated that Elena's prescription medications were

not in her system at the time of death.¹⁶⁸ On May 16, 2022, Amelia was criminally charged by a grand jury of child abuse that recklessly caused or permitted Elena's death.

CYFD's parallel investigation substantiated Amelia's neglect of Elena. On May 5, 2022, the Department filed an affidavit seeking custody of Amelia's children. In the filing, CYFD concluded that:

"The safety threats to the children include: a caregiver (mother) who does not meet the children's immediate and basic needs for care, supervision, food, clothing, and/or medical or mental health intervention and current circumstances; combined with information that the caregiver has likely, seriously maltreated a child in her care which resulted in the death of the child, suggests that the other children, who were exposed to the neglect and death of their sister, are also in at risk and in danger of neglect."

A Children's Court judge granted the Department's request, finding that it was necessary for the children's protection that they remain in CYFD custody. But CYFD's rationale in seeking custody of Amelia's children—a failure to meet her children's needs for care, supervision, food, clothing and medical intervention—was evident well before Elena's death. Intervention to protect Amelia's children came too late.

In the years since Elena's death, CYFD continued to pursue reunifying Amelia and her four surviving children. Despite seven years of serious neglect and seven prior investigations, CYFD's solution is to return the children back to the same "caregiver" who continuously endangered them in the first place.¹⁶⁹ In July 2025, a CYFD PPW testified in Amelia's criminal case *in support of her release from jail*. During the testimony, the families assigned PPW affirmed CYFD's position that reunifying the children with Amelia was appropriate, despite [acknowledging prior Department and law enforcement investigations for child endangerment](#) in 2019 and Amelia's [failure to comply with their investigation](#).

The gravity of this testimony cannot be overstated. A representative of CYFD, the entity legally responsible for the care and protection of children, testified in favor of releasing Amelia from jail—despite Amelia being accused of killing her special needs daughter through gross neglect—so the Department could reunite Amelia with her surviving children.

c. Proper investigation and intervention could have saved Elena

¹⁶⁸ In September 2019, CYFD became aware that Elena's parents were consistently failing to pick up her prescription medications.

¹⁶⁹ Beyond poor judgment, CYFD's continued pursuit of reunification violated NMSA 1978, § 32A-4-29(G), which requires the Department to seek to terminate parental rights when a child has been in foster care for 15 of the previous 22 months. As of July 2025, Amelia's children were in custody for 39 months.

CYFD’s approach toward Amelia and her family failed in four material respects, each of which could have changed the outcome for Elena.

First, CYFD repeatedly downplayed the severity and importance of the family’s uninhabitable living environment. As early as October 2018, CYFD was alerted to filthy conditions in Amelia’s home, including trash throughout the home, insufficient food, urine and defecation in Elena’s living space, and bug infestations. In July 2019, law enforcement again reported cockroaches, a strong urine odor, a soiled mattress, and lack of food. When Elena died in May 2022, their home smelled of urine and feces with visible bugs throughout. CYFD evaluated each report in a vacuum, but should have recognized the family’s pattern—horrific living conditions that would become temporarily remediated after CYFD involvement—followed by a prompt return to the same conditions once the investigation was closed.

Second, CYFD’s investigations reveal a fundamental inability to properly assess and substantiate credible reports of neglect. Despite clear evidence—including law enforcement observations, corroborating statements from collateral witnesses, and medical provider reports—multiple investigations were incorrectly unsubstantiated.¹⁷⁰ This pattern reveals a flawed practice in which CYFD investigators conflate the presence of mitigating factors with a lack of evidence to substantiate the report. According to child protective services expert [Dr. Melissa Moyer’s report](#),¹⁷¹ there were at least three investigations that were incorrectly unsubstantiated.¹⁷² Dr. Moyer noted that “prior unsubstantiated cases are labeled unsupported, unfounded, or even untrue, often being dismissed by staff entirely when conducting assessments of the family.” These findings highlight CYFD’s tendency to downplay subsequent allegations as similarly unfounded, rather than identifying them as part of a dangerous pattern developing within the family.

Third, CYFD consistently violated its policies governing supervisory oversight and case closure. Dr. Moyer’s analysis determined that CYFD investigation supervisors routinely failed to conduct required pre-initiation staffings, which deprived less experienced investigators of critical guidance. CYFD also disregarded mandated “3+ staffings” with supervisors and county office managers, missing opportunities to detect patterns of neglect and initiate appropriate interventions.¹⁷³ In addition, investigations were frequently closed

¹⁷⁰ Each of these sources of information would have met the definition of credible evidence supporting a conclusion that the child had been abused or neglected and warranting a report. See CYFD Invest. Proc. PR 17, § 5.1 (“Investigation Decision: Substantiated”).

¹⁷¹ Dr. Moyer CYFD Final Report at 2.

¹⁷² CYFD improperly unsubstantiated reports of neglect from October 3-4, 2018; September 27, 2019; and January 31, 2020. In each of these instances, there was indisputable credible evidence that neglect occurred.

¹⁷³ CYFD was required to conduct a 3+ case staffing starting with the September 27, 2019, referral, but records show this occurred only during the October 2018 investigation.

well past the 45-day deadline, some by over 200 days, without current assessments of the children’s needs or living conditions. Delayed closures create cascading harms, including ballooned investigator caseloads and leaving SCI employees to screen new reports without current family information.

Fourth, despite repeated high-risk assessments, CYFD failed to pursue necessary resources and services for Amelia’s family. CYFD’s support of Amelia’s family should have intensified following the law enforcement encounters in October 2018 and July 2019. Instead, the Department ceased providing services at all, relying solely on Amelia’s word that none were needed. This absence of referrals was not only inconsistent with what the circumstances dictated, but also violated protocol. CYFD policy provides a service matrix¹⁷⁴ to guide investigators on service needs based on safety and risk assessments. Even when children are deemed “safe,” moderate and high-risk levels always require resources and escalating interventions.

Table 5. Service Matrix from CYFD investigation procedures, 8.10.3.19.

Service Matrix			
Safety Decision	Low Risk	Moderate Risk	High Risk
Safe	No services required.	Information and resources provided to the family.	Warm Handoff to: • PSD In Home Services • Intensive Family Support Services (IFSS) • Family Support Services (FSS); or • Other intensive local community service

In CYFD’s five investigations between September 2017 and January 2020, risk assessments confirmed there was a high risk of repeat neglect by Amelia against her children. In each of these instances, CYFD failed to refer Amelia to any Department-run programs or community providers to assist her family.

Despite [years of documented concerns over seven investigations](#)—including repeated law enforcement interventions, school reports of neglect, chronic poor living conditions, missed medical appointments, and frequent high-risk assessments—CYFD consistently failed to take decisive action to safeguard Elena and her siblings. Elena’s death was not the result of a single oversight, but the tragic culmination of years of poor judgment, [policy violations](#), and Department inaction.

¹⁷⁴ CYFD’s internal procedures include a matrix (or rubric) intended to guide service referrals. See CYFD Invest. Proc. PR 18, § 5.3 (“Once Initiation is Completed”), PR 19, § 5 (“Investigation Disposition”).

3. Case Study: “Gloria F.”

The case of Gloria F. stands as one of the most alarming examples of CYFD’s failure to protect at-risk children. Despite nearly two decades of drug abuse, domestic violence, and repeated reports of child endangerment, there was no significant intervention by CYFD—culminating in the preventable death of an infant and the continued exposure of Gloria’s other children to abuse and neglect.

Gloria F. had six children with two different partners. Gloria and Eric R. were the parents of Jessica R. (YOB: 2005), Henry R. (YOB: 2008), and Aaron R. (YOB: 2016). Gloria and Paul H. were the parents of Levi H. (YOB: 2019), Liam H. (YOB: 2020), and Lucas H. (YOB: 2021). Gloria’s oldest child Jessica R. gave birth to Natalie N. (YOB: 2021), who also lived with Gloria.

CYFD investigated 23 abuse and neglect reports involving Gloria F. between 2005 and 2023. The abuse and neglect referrals shared a common theme: Gloria used drugs, neglected her children, and put them in situations that compromised their health and safety. CYFD was fully aware that:

- Gloria F. and her partner Paul H. were using drugs in front of their children;
- Domestic violence between Gloria and Paul was occurring in the children’s presence;
- Gloria consistently neglected her children’s needs by failing to take them to critical medical appointments and following physician recommendations; and
- Gloria and Paul were physically abusing their children.

Despite demonstrably sufficient evidence in most circumstances, CYFD only substantiated 5 of the 23 reports received documenting Gloria’s abuse and neglect. Even when CYFD substantiated the allegations and temporarily removed Gloria’s children, CYFD remained intent on reunifying Gloria and her children. CYFD again demonstrated their priority to reunify children with biological parents, however dangerous, to the detriment of the children’s safety.

a. CYFD’s failures to address Gloria F.’s drug addiction caused the death of eight-month-old Lucas H.

CYFD enabled Gloria by not requiring treatment of her addiction to methamphetamine and other narcotics. Four of Gloria’s six children were born exposed to drugs. CYFD received its first abuse and neglect report involving Gloria on October 24, 2005, when Gloria’s oldest child Jessica was born exposed to methamphetamine. [CYFD case notes](#) show Gloria admitted to CYFD that she had been using methamphetamines since age 18, and that she used four times during her pregnancy. CYFD substantiated the report,

allowed Gloria to retain custody of her child, and referred her to drug counseling. A CYFD note from February 2, 2006, states that CYFD was aware that Gloria never kept any appointments for drug treatment.

In 2008, Gloria second child Henry R. was born with an unprescribed pain medication in his system. During CYFD's investigation¹⁷⁵ of the incident, Gloria told the CYFD investigator that she thought she was taking Tylenol but accidentally took a prescription opioid. Gloria admitted to the CYFD investigator that she completed a detox program in May 2008 and denied any ongoing substance use. Without corroborating those claims, CYFD deemed the allegations unsubstantiated and referred Gloria for parenting classes.

CYFD continued to demonstrate awareness of Gloria's substance abuse, but failed to require that she complete an inpatient treatment program. After another investigation initiated in early January 2012, a CYFD case closure note dated January 26, 2012 acknowledges that Gloria's history of substance abuse was a risk factor for maltreatment:

Home visit completed: Unable to contact mother to complete. Mother did not return calls.

All household members interviewed: no. Worker verified family lives at listed address, but mother did not contact worker.

Parent interview (including absent or non-involved parent: Mother did not cooperate with interview. Did not contact worker.

Safety Assessment SDM Score: Conditionally Safe based on collateral contact information.

Safety Threats/Protective Capacities Identified/Safety Plan: Child able to report. She did not make any report of abuse, neglect, or fear of caretakers.

Screened out referrals/Safety Assessments completed: n/a

Risk Assessment SDM Score: Moderate due to CPS history.

Risk Factors Identified: Mother's history of sub. abuse and her failure to cooperate with investigation.

The pattern continued. On March 27, 2012, Gloria was arrested for outstanding fraud warrants from both New Mexico and Texas. According to [CYFD case notes](#), Gloria's then four-year-old son Henry R. was sitting on her lap in the passenger seat and was not properly restrained. Gloria's mother, Sheri Ann F., told the CYFD investigator that Gloria was using drugs and had a substance abuse problem. The CYFD investigator noted Gloria was dirty, unkept, and appeared to be under the influence. Despite these observations and statements, CYFD deemed the allegations unsubstantiated, without requiring Gloria to complete a drug test. CYFD's [closure staffing note](#) indicates a suspicion of drug use but concludes that "no evidence to support that [drug use] has been found at this time." Beyond allegations of substance abuse, CYFD noted that "[Gloria's] chaotic lifestyle is also a risk factor for abuse."

¹⁷⁵ CYFD's staffing notes incorrectly refers to the newborn as "her" when referring to Henry R.

Gloria's methamphetamine use continued to endanger her children. According to a [CYFD investigation opened May 27, 2016](#), Gloria was involved in a motor vehicle accident with her children in the car. A drug test confirmed that Gloria was under the influence of methamphetamine. Gloria admitted to a CYFD investigator that she relapsed after her ex-husband was released from prison. Rather than pursue more impactful alternatives, CYFD temporarily placed Gloria's children with a safety monitor.¹⁷⁶ A CYFD Substance Abuse Assessment conducted in July 2016 noted that Gloria continued to deny the frequency and amount of her substance use. The assessment stated that, "without professional treatment/interventions, [Gloria's] children are at a risk for harm or neglect." Despite clear signs that Gloria was unable or unwilling to appreciate the risk that her continued narcotics use posed to her children, [CYFD closed the investigation](#), returned her children to her care, and referred her to an intensive outpatient drug treatment program.

On January 4, 2020, Gloria's fifth child, Liam H., was born exposed to methamphetamine. According to an updated [CYFD Substance Abuse Assessment](#), Gloria admitted to using methamphetamine during the late stages of her pregnancy. Throughout the pendency of CYFD's investigation, Gloria and Paul continued using methamphetamine. CYFD closed the matter anyway. In a [case closure staffing note](#), CYFD recognized that while Paul and Gloria were engaged in substance abuse treatment, they continued to test positive.

By October 2021, CYFD's acquiescence in Gloria's ongoing drug use contributed to harm suffered by yet another child. Gloria's sixth child, Lucas H., was born exposed to marijuana and methamphetamine. A [CARA plan](#), designed to offer support services to mothers of prenatally drug-exposed newborns, included a note from a medical provider that Gloria denied using methamphetamine during her pregnancy. Notably, Gloria declined substance abuse counseling services as part of the CARA plan.

Gloria's persistent and unchecked drug addiction, exacerbated by CYFD's insufficient intervention, eventually **caused the death of eight-month-old Lucas H.** On June 17, 2022, law enforcement and paramedics were dispatched to Gloria's apartment after Gloria's older children found Lucas not breathing. Police lapel video shows Henry R. telling officers that Lucas was co-sleeping with Gloria. He heard Lucas crying around 5:00 am and went to go feed him a bottle and then went back to bed. Henry was woken up by brothers Liam and Levi, who told him Lucas was "stuck." Henry went downstairs and found

¹⁷⁶ CYFD policy defines a safety monitor as an individual designated to oversee the care of a child when concerns about parental capacity or safety exist. Their primary role is to ensure that the parent or guardian complies with the safety plan and that the child remains safe during the plan's duration. CYFD Invest. Proc. PR 10, § 10.1 ("Safety Plans").

Lucas between Gloria's mattress and the wall. He was face down, unresponsive, and wrapped in a blanket.

APD reported to CYFD that the home where Lucas was found dead was filthy. Police took photographs of Gloria's apartment, which showed an uninhabitable living space where six children were living with Gloria. In Gloria's bedroom, officers recovered cocaine and methamphetamine on a tray close to the bed where Gloria and Lucas were sleeping.

CYFD initiated an investigation into the death of Lucas. On the date of Lucas' death, a drug test revealed that [Gloria F. tested positive](#) for methamphetamine and ecstasy. Tragically, hair follicle samples uncovered that [three of the five children](#) in the home also tested positive for methamphetamine. Gloria F. admitted to CYFD she was using methamphetamine but denied that it was the cause of Lucas' death. In a later [Psychosocial Assessment](#) ordered by CYFD, Gloria acknowledged a prior methamphetamine addiction.



Figure 11. Photos from APD investigation on June 17, 2022. Clockwise from top left: Cocaine, meth, and drug paraphernalia; stains and rotting food; tools and chemicals; and aerosol spray.

The [autopsy findings](#) for Lucas H. were released in November 2022. The OMI determined that Lucas died of asphyxia due to an unsafe sleeping environment, and that methamphetamine toxicity in his system significantly contributed to his death.

b. CYFD turned a blind eye to domestic violence, physical abuse, and the medical neglect of Gloria's children.

CYFD's failures to address Gloria's drug addiction resulted in other forms of abuse and neglect. On August 21 and 23, 2019, CYFD received reports that Gloria was exposing her children to domestic violence in the home. A [CYFD case closure staffing note](#) shows that Gloria, her daughter Jessica, and her mother all reported to CYFD that Gloria's partner, Paul H., abused her in front of the children. On August 21, 2019, Gloria filed a [petition](#) in court seeking an order of protection from Paul's domestic violence. In the petition, Gloria accused Paul of pushing her around, spitting in her face, and beating her up. Gloria described having to pepper spray Paul in front of her children because he was charging at her when she was 14-15 weeks pregnant. Despite the disturbing accounts in Gloria's petition—and corroborated statements from two other individuals familiar with Paul and Gloria's relationship—CYFD still deemed the allegations unsubstantiated.

Nearly a year later, Paul's pattern of domestic violence remained unchanged. On July 6, 2020, Gloria reported to a CYFD investigator that Paul had hit her while she was holding 10-month-old Levi. During a home visit from the CYFD investigator, Gloria described Paul's violence and the danger it posed to Levi:

I got home at 2 a.m. after that, my boss dropped me off. I went to pick up the baby and [REDACTED] showed up. He hit me while holding [REDACTED]. My friend, [REDACTED] saw him hit me. [REDACTED] left and came back and broke [REDACTED] windshield." She reported that [REDACTED] was inside the home when he hit her. I asked if the other children saw [REDACTED] hit her and she said "no." She reported that she purchased her new car the next day. She explained that the windshield on the new car was busted and had the restraining order filed on Friday for herself and the kids. I asked if [REDACTED] has a current drug use, she said "he shoots up meth. I was finding syringes in the bathroom at the old house." I asked what about now, she said "he misses because you can see abscesses on his arms. When I know he's high, I never let him around the kids."

In another report to CYFD on January 12, 2021, a medical professional expressed concerns that Gloria's children were being exposed to domestic abuse after Gloria arrived at the hospital with a black eye. CYFD again deemed the allegations unsubstantiated. Per a [CYFD case closure staffing note](#), both Paul and Gloria declined parenting courses, counseling, and early intervention services offered by CYFD.

Gloria was not the only victim of violence in her household. CYFD received several reports that the children themselves were victims of Gloria and Paul's physical abuse. CYFD opened an investigation into abuse against the children on September 27, 2021, after a pre-school staff member reported that Levi had injuries and scratches on his body. The staff member told a CYFD investigator that she had photographs of Levi showing various scratches, cuts, and bruises in different states of healing. An New Mexico State Police

(NMSP) officer assessed the wounds and determined that a safety plan and CART exam¹⁷⁷ were necessary. Gloria denied to CYFD that the injuries were from physical abuse and instead claimed they were a result of Levi and Liam playing rough. CYFD took her word, deemed the allegations unsubstantiated, and referred Gloria and Paul to voluntary parenting and child abuse prevention services.

CYFD continued to receive reports that Gloria's children were being physically abused. On March 25, 2022, and April 14, 2022, a CYFD investigator observed visible injuries to two-year-old Liam after being called to his daycare. Liam had a scratch above his eye and a small cigarette burn on his left wrist. A police report authored on April 14, 2022, noted the presence of the cigarette burn on Liam being perfectly circular and unlikely to be caused by accident:

NARRATIVE

On 4/14/22 I was dispatched to a daycare located at 10111 Constitution Ave NE in reference to a physical abuse of a child call. Remarks on the call state a child was dropped off by their father and the child pointed to their wrist. When the employee of the daycare looked at the child's wrist they observed a circular burn. Remarks further state the father disclosed it was an accident. The caller believes the injury occurred the day before 4/13/22 and the child was not present that day.

Upon arrival, I contacted [REDACTED] who explained a child identified [REDACTED] was dropped off by his father [REDACTED]. When [REDACTED] arrived he was pointing to his right wrist, when [REDACTED] looked she observed a circular burn on [REDACTED] wrist. [REDACTED] openly disclosed it was an accidental injury and [REDACTED] had grabbed cigarettes. Once [REDACTED] left, [REDACTED] contacted law enforcement. [REDACTED] has never arrived with injuries before and did not appear to be afraid of his father. Due to [REDACTED] age he was unable to provide any details of the event to [REDACTED]. [REDACTED] also advised CYFD arrived earlier and had only taken photos of the burn and left the scene. The CYFD investigator did not leave their contact information.

[REDACTED] brought [REDACTED] into a room where I was able to check [REDACTED] physically. I did observe the same burn mark described in [REDACTED] statement. The burn was in the middle of the wrist just before the hand which was perfectly circular. It did not appear possible the wound could have been caused by [REDACTED] simply grabbing a cigarette. I also observed scratches on [REDACTED] face, [REDACTED] advised the scratches came from playing earlier in the day. I did not observe any other wounds on [REDACTED] person.

After checking [REDACTED]'s wound, I requested a field investigator to take photos of the injury. I also contacted CYFD via telephone who advised [REDACTED] mother [REDACTED] and [REDACTED] have over 20 CYFD cases in their history. CYFD was able to provide me the information of the investigator who responded earlier in the day. I did contact the worker and briefed him on the call and would also update him throughout the investigation.

Despite reports of physical abuse from daycare workers and law enforcement, CYFD again unsubstantiated the allegations. CYFD stuck to its playbook, offering parenting classes and other voluntary services that Gloria and Paul could (and did) decline. Gloria's repeated refusal to engage in services, coupled with CYFD's failure to escalate its response to numerous reports of abuse, deprived Gloria's children of any effective intervention.

CYFD likewise frequently disregarded the dangers posed by Gloria's ongoing neglect of her children's medical needs. Gloria's son Liam was born with dysphagia, a swallowing disorder that requires using a feeding tube to ingest food. Liam's medical records show that between January and April 2020, he was transported to the emergency room three separate

¹⁷⁷ A Child Abuse Response Team (CART) exam is conducted by specialized medical providers who evaluate allegations of physical abuse and neglect against children. A CYFD investigator may arrange for a CART exam to document injuries. CYFD Invest. Proc. PR 11, § 8.3 ("Medical Examination").

times for medical complications. In CYFD investigator case notes, it was described that “[Liam] has basically died three times and was resuscitated each time.”¹⁷⁸

On July 6, 2020, and August 14, 2020, CYFD received reports that Gloria continued to miss medical appointments critical to Liam’s care. When one delayed post-surgery appointment finally occurred, Liam was found malnourished, and had not gained weight due to Gloria’s admitted failure to mix his formula correctly. CYFD also learned that Gloria ignored physician orders prohibiting oral feeding—a directive essential to prevent choking given Liam’s dysphagia. [CYFD interviewed a hospital social worker](#) who observed Gloria giving Liam a push pop ice cream despite his inability to swallow safely. Despite this extensive evidence, CYFD unsubstantiated both reports.¹⁷⁹

Gloria continued to miss medical appointments into 2021. A hospital worker at Presbyterian Pediatric Care reported that Gloria cancelled an appointment for Liam on February 2, 2021, and was a “no-call no show” on February 22, 2021. CYFD again deemed the allegations unsubstantiated, noting that Gloria rescheduled the appointment and was able to demonstrate adequate understanding of how to feed Liam.

In total, between March 25, 2020, and March 12, 2021, CYFD received seven abuse or neglect reports involving Liam, six of which documented medical neglect. Despite credible firsthand evidence—including multiple social workers reporting that Gloria missed appointments and ignored medical advice regarding Liam’s care—CYFD considered all seven reports unsubstantiated.

c. CYFD still planned to reunify Gloria with her children after the death of Lucas H.

Lucas’ death did not improve Gloria’s parenting or make her more receptive to assistance. While at Lucas’ pre-funeral viewing, Gloria wore a shirt that said, “[D]on’t ask about my baby, fuck you.” Gloria’s sister later [told a CYFD employee](#) that Gloria began smoking a marijuana joint in front of other mourners in the parking lot at the funeral.

After Lucas’ death, a Children’s Court Judge entered an [Ex Parte Order](#) on June 29, 2022 removing Jessica, Henry, Levi, and Liam from Gloria’s custody. Despite this order, CYFD still planned to reunify Lucas’ siblings with Gloria if she engaged in substance abuse treatment, counseling, and parenting classes—the same resources suggested by CYFD on multiple occasions, and which Gloria remained unwilling to accept or complete.

¹⁷⁸ CYFD Investigator FACTS narrative notes. Report date of May 22, 2020. Note date of June 4, 2020.

¹⁷⁹ Id.

Indeed, Gloria continued to test positive for methamphetamine and other narcotics during CYFD’s open investigation into Lucas’ death and pending permanency determination. Despite Gloria’s plan requiring her to pass random drug tests, her [drug test results](#) were positive for methamphetamine and/or marijuana on June 17, 2022, June 28, 2022, July 25, 2022, and November 17, 2022.

CYFD nonetheless initiated a trial home visit, returning the children to Gloria’s home. During this trial home visit period, Gloria allegedly resumed physical abuse of her children. In mid-December 2022, CYFD received a [CPS Intake Report](#) stating that Gloria was seen kicking Liam and Levi on their bottom while telling them to get into the car. The reporter noted that Liam and Levi were both crying as Gloria was yelling at them. CYFD concluded that there was insufficient evidence to substantiate the allegations because the two-year old brothers themselves did not disclose the abuse. CYFD chose to not terminate the trial home visit.¹⁸⁰

A case note entered by the PPW shows that CYFD knew of further troubling behaviors by Gloria during the trial home visit. In fact, Levi and Liam’s therapist went so far as to recommend that CYFD discontinue the trial home visit due to negative changes in Levi and Liam’s behaviors. The PPW wrote:

12.22.2022 – Provider Staffing
PPWS – [REDACTED]
GAL – [REDACTED]
CCA – [REDACTED]
Karen Baca – [REDACTED] therapist

Baca – change in behavior when the children started to have overnights with mother. Resource parent and grandmother told Baca that mother lets’ the children do whatever they want. The last month – mother was late a couple times while taking the children to therapy. Mother used his grandmother as a punishment – if you do ____, you won’t see grandmother. Recommends the THV and overnights stop. Concerned that Mother wasn’t truthful about the incident and if the children did not disclose. Baca wants RP to bring the children to therapy so the children open to talk.

As another example, CYFD received a report of Gloria physically abusing Liam on January 3, 2023, during the trial home period. Liam’s therapist reported to CYFD that she observed red marks on Liam’s face. Liam—who was turning three-years-old—even told the therapist, “Mama slapped me.” CYFD’s investigator observed a red line on the top of Liam’s lip and noted that his cheek was red. The [CYFD investigator further learned](#) that Liam had

¹⁸⁰ If reunification remains the permanency goal, CYFD must submit a transition home plan to the court, which must result in a trial home visit within six months of the initial permanency hearing. CYFD, [Permanency Planning Procedures](#) (8.10.8 NMAC) PR 12, § 9.2 (2024) (hereinafter “CYFD Permanency Planning Proc.”). While trial home visits help assess caregiver competency, CYFD must critically evaluate their appropriateness in each case and the PPW must formally reassess child safety before any trial home visit. *Id.* at PR 9, § 6.1 (“Formal Assessment”), PR 12, § 6 (“Initial Assessment Plan”). In this case, repeated positive drug tests and allegations of physical abuse should have resulted in the termination of any such visits.

bruises and that neither he nor Levi had been to daycare since starting the trial home visit. Despite more than sufficient credible evidence to support a finding of abuse, CYFD inexplicably deemed all allegations against Gloria unsubstantiated.

CYFD chose not to proceed with more robust interventions or require additional compliance with the treatment plan despite multiple recent abuse and neglect allegations. On February 7, 2023, CYFD dismissed the abuse and neglect petition filed against Gloria after Lucas' death. Jessica, Henry, Liam, Levi, and Natalie were returned to Gloria's care full-time without any ongoing CYFD oversight.

CYFD later received a *twenty-third abuse and neglect report*, alleging that Gloria was exposing children in her home to drugs. On March 14, 2023, Gloria's then two-year-old granddaughter Natalie arrived at day care smelling like marijuana. CYFD required Natalie to take a hair follicle drug test, which returned positive for [methamphetamines and marijuana](#). Gloria also tested positive for [methamphetamines and marijuana](#), while her daughter Jessica (Natalie's mother) tested negative for all substances.

On April 7, 2023, APD searched Gloria's residence and seized drug paraphernalia, as well as substances that a forensic laboratory determined to be [methamphetamine and marijuana](#). APD Detective Chris Niederhauser, who had been investigating the circumstances surrounding Lucas' death, broadened the scope of his inquiry to include Gloria's role in exposing her children to dangerous narcotics. Detective Niederhauser informed CYFD that he intended to place Gloria's children on a 48-hour hold.

CYFD disagreed with APD's decision to remove Gloria's children from her custody. A legal staffing with CYFD's Children's Court attorney, county office manager, and the investigations team assigned to Gloria's case all determined that keeping Gloria's children on a safety plan with a referral to CYFD's In-Home Services "could best serve this family."¹⁸¹

Despite long-standing efforts to avoid removal, on April 18, 2023, CYFD finally filed a petition to obtain custody of Gloria's children. That decision was made only after CYFD learned that APD would soon arrest Gloria for child abuse related to Lucas' death in June 2022. In its petition, CYFD cited a "long CPS history, domestic violence history, substance abuse, lack of cooperation and follow-through with recommended services, and continued neglect." CYFD's petition further noted:

¹⁸¹ In-Home Services is a voluntary program in which an in-home services practitioner provides parenting, substance abuse, domestic violence and other support to families, aimed at preventing removal of a child by addressing danger indicators and enhancing a parent's protective capacities.

22. It would be contrary to the children's welfare to return home due to the lack of caregiver supervision. [REDACTED] has tested positive for illegal substances and according to the testing facility [REDACTED] would have had to ingest, not just be around, methamphetamine and amphetamines to have the reported levels in her system. The long CPS history, domestic violence history, substance abuse, lack of cooperation and follow-through with recommended service, and continued neglect by [REDACTED] [REDACTED] lacks the protective capacities to mitigate the safety threats. Additionally, it is further concerning that she has placed her children in the care of others who are not safe, when safe alternatives existed. [REDACTED] [REDACTED] and [REDACTED] are vulnerable children due to their ages and inability to care for or protect themselves. Despite reasonable efforts to prevent removal, this family. Therefore, the Department is requesting that [REDACTED] and [REDACTED] and [REDACTED] should be placed in CYFD custody.

Each of these realities existed long before CYFD begrudgingly filed the petition. Had CYFD intervened earlier, Gloria's children might have avoided considerable trauma and abuse. Even after filing of the abuse and neglect petition however, CYFD maintained the goal of eventually reuniting the children with Gloria. Indeed, CYFD's [Initial Assessment Plan](#) for Gloria's children sought reunification contingent on substance abuse treatment, a mental health evaluation, and successful visits at the discretion of the Department. Although it is ordinarily required that the Department make reasonable efforts to reunify a child with their parents, those efforts are not mandatory when they would be futile or where "aggravated circumstances" are present.¹⁸² Aggravated circumstances were present in Gloria's case.

The timing and substance of CYFD's initial assessment plan is telling. CYFD's plan seeking reunification was made a mere four days after a Bernalillo County grand jury returned an indictment charging Gloria with seven felony charges associated with Lucas' death. Gloria later pled guilty to second degree child abuse resulting in death, and on September 19, 2024, was [sentenced to 12 years](#) in prison. Considering CYFD's assessment plan and dismissive treatment of past abuse or neglect reports, it is unlikely the Department would have sought removal of Gloria's children had it not been for APD's criminal investigation and Gloria's subsequent incarceration.

¹⁸² New Mexico law and CYFD policy state that a plan of reunification may not be appropriate in most cases involving "aggravated circumstances," in which CYFD has knowledge that a parent has (1) attempted, conspired to cause, or caused great bodily harm to the child or great bodily harm or death to the child's sibling. See CYFD Permanency Planning Proc. PR 13, § 6.2 ("Reunification Not Appropriate"); 8.10.8.12(A) NMAC (explaining that the goal of permanency planning is reunification "unless the court finds that aggravated circumstances exist"). In other words, Gloria's culpability in Lucas' death in June 2022, without even considering the many other instances of abuse, would have been sufficient for CYFD to forego a plan of reunification for Lucas' siblings.

d. CYFD violated New Mexico law and its policies by failing to remove Gloria F.'s children.

All told, between 2005 and 2023, CYFD received [23 abuse and neglect reports involving Gloria F.'s children](#). Throughout Gloria's nearly 20-year involvement with the child welfare system, CYFD [violated New Mexico law and its own policies](#) innumerable times.

During the [NMDOJ's consultation with Dr. Melissa Moyer](#), she identified several CYFD actions and omissions that contributed to Lucas' death, including: (1) disregard of Gloria's extensive protective services history; (2) use of temporary placements without addressing core safety issues in the home; (3) inaccurate application of safety and risk assessment tools; and (4) inadequate supervisory support to investigators in the field.

Dr. Moyer pointed to CYFD's failure to ensure Gloria's engagement with support services as a primary factor in the repeated maltreatment of Gloria's children. Dr. Moyer noted that with high-risk families, referrals to services such as wraparound services, in-home clinical case management, family support services, and out-of-home childcare are mandatory. In Gloria's 23 investigations, there were numerous instances where CYFD either did not refer Gloria to appropriate services or did not subsequently verify that Gloria and her family were receiving services.

Dr. Moyer also noted that there was minimal evidence that CYFD investigators received meaningful or formal support from supervisors. In each of Gloria's cases, there should have been a minimum of three supervisory staffings—one prior to initiation of the investigation, again as a repeat maltreatment case with higher level supervisors, and finally at case closure. Throughout Gloria's 23 investigations, there should have been nearly 70 supervisory staffings. Each missed staffing represented an opportunity for stronger oversight: safety and risk tools could have been validated, and appropriate service referrals secured. Instead, supervisory staffings fell well below requirements, leaving critical chances for intervention unrealized.

CYFD fell far short of even minimum standards in handling Gloria's cases. While temporary out-of-home placements were used as a proverbial band-aid during some of the 23 investigations, CYFD consistently sought to reunify Gloria's with her children under any circumstances, with no regard to the children's well-being. CYFD had extensive opportunities—and express legal obligations—to protect Gloria's children. Instead, CYFD chose inaction over intervention, even when Gloria's ongoing drug abuse and abusive and neglectful parenting showed no signs of improving. The result was a profound failure to uphold the Department's duty to protect the children in its care, culminating in Lucas' preventable death.

4. Case Study: “Daniella C.”

Daniella C. had five children: Mateo C. (YOB: 2008), Noah S. (YOB: 2018), Tomas S. Jr. (YOB: 2019), Ava W. (YOB: 2022), and Sofia W. (YOB: 2023). Between 2015 and 2024, CYFD initiated 12 investigations into allegations of abuse and neglect by Daniella involving *each* of her five children, of which eight were substantiated. Despite her alarming child protective services history, CYFD was quick to reunify her with her children, to their detriment, at the earliest possible opportunities.

Daniella did more than simply neglect her children—she brutally battered and tortured them. The substantiated allegations of abuse include instances where:

- Daniella shoved a pair of underwear in her son’s mouth and restrained him to prevent the child from calling law enforcement.
- Daniella’s eight-month-old child suffered a skull fracture and a brain hemorrhage due to Daniella’s abuse.
- Daniella’s infant child suffered permanent disfigurement after breaking her jaw, under circumstances that medical providers doubted were accidental.

Daniella’s first encounter with CYFD was in April 2015, after law enforcement responded to a domestic disturbance between Daniella and her boyfriend. A [CPS Intake Report](#) indicated that Daniella broke down a door with an axe while in a verbal disagreement with her boyfriend and then fled the scene before the police arrived. The report indicated that Mateo C. was present for the altercation and that there was a history of altercations between Daniella and her boyfriend.

CYFD conducted an inquiry into the April 2015 incident that was both in violation of internal policies and well below recognized standards in child welfare investigations. CYFD failed to interview the boyfriend who made the report and failed to account for any facts established by law enforcement. When interviewed by CYFD, Daniella denied all allegations, prevented investigators from speaking with others who may have had knowledge regarding the situation, and refused to allow CYFD to interview her son. CYFD accepted these responses at face value. CYFD closed the investigation three weeks late.¹⁸³ According to a case closure staffing report, Daniella refused to engage in any services offered by CYFD:

¹⁸³ A CYFD investigator is required to complete an investigation within 45 days after the case is accepted. Such deadlines should be realistic under any scenario, but particularly so when an investigation is wholly deficient. 8.10.3.17(A) NMAC; CYFD Invest. Proc. PR 17, § 5 (“Investigation Decision”).

Date home visit made and condition of the home: 04/13/2015

I was able to set up a home visit on April 13, 2015 where I was able to go to the home and observe the home and the home was appropriate and clean. I asked if she had any collaterals. She said she did not want anyone involved and wanted this to be closed. She did not want to cooperate and was not very forthcoming. I tried to ask her about the interview with her son again and she refused to let me interview him on a separate basis.

Daniella's [second encounter with CYFD](#) occurred less than a year later, in March 2016, when NMSP responded to a report that she was intoxicated and fighting with another woman outside of a general store in Peñasco, New Mexico. Eight-year-old Mateo C. was present to witness his mother acting violent while under the influence. Daniella admitted to driving intoxicated from Santa Fe to Peñasco with Mateo in the vehicle.

Once again, CYFD completed a deficient investigation in violation of New Mexico law and its own policies. CYFD failed to conduct the required assessment of Daniella's home, failed to insist on drug or alcohol testing to ensure prospective safety of Mateo, and failed to speak to any key witnesses regarding the event. A [case closure staffing report](#) notes that CYFD's investigator was unable to locate Daniella, and on March 23, 2016, the Department closed the investigation and deemed the allegations against her unsubstantiated. Although CYFD typically has 45 days to complete the required steps, it closed the March 2016 investigation just nine days after it was opened. This time frame highlights CYFD's failure to diligently investigate this incident. CYFD missed an early opportunity to identify Daniella's chronic substance abuse and aggressive behavior, which perhaps could have spared Mateo and his siblings the trauma that would follow.

On March 10, 2017, CYFD investigated another report of abuse by Daniella against then 8-year-old Mateo. A school administrator at Mateo's elementary school made a [report to CYFD](#) after noticing red marks on Mateo's face resembling scratches from a handprint and a brown and purplish bruise on his shoulder blade. Mateo told school staff that his mother would sit on him, slap him, punch him, kick him, and beat him until there was blood. According to [CYFD investigator notes](#), Mateo later disclosed to CYFD that his mother grabbed him by the hair and "threw him everywhere." Mateo further revealed that Daniella would hit him on his back with a belt "the way a jockey whips a horse," and that his mom "just acts crazy sometimes." CYFD also spoke with Mateo's uncle, who lived in the same home. The uncle expressed concerns about Daniella's parenting and suspected she was overwhelmed.

Given Mateo's statements and injuries, CYFD substantiated the claims of abuse against Daniella. CYFD's investigator did not, however, attend a subsequent Safehouse

interview¹⁸⁴ or incorporate information learned from the interview into their findings. In fact, CYFD took no action to remove Mateo from Daniella’s custody. Per a CYFD Investigation Closure Report, Mateo was returned to Daniella’s custody on March 21, 2017, only 11 days after the incident. Although CYFD deemed Mateo “conditionally safe” with a safety monitor, the Department failed to reassess and address any remaining danger indicators prior to closing the investigation, again violating its own policies. CYFD referred Daniella to family support services to improve her parenting skills but did not verify whether Daniella acted on the referral.

Unsurprisingly, CYFD’s slap on the wrist to Daniella failed to protect Mateo from future abuse. Less than five months later, in July 2017, CYFD received another abuse and neglect referral involving Mateo. This time, Daniella was reported to have been severely intoxicated at an apartment complex with Mateo present. An APD report stated that Daniella was threatening neighbors and bit someone who was trying to calm her down. Officers on scene determined that Daniella was too intoxicated to properly care for Mateo, and she was arrested for child endangerment.

During the CYFD investigation, Daniella finally acknowledged a persistent substance abuse issue. Through a [CYFD Substance Abuse Assessment](#), she admitted to mixing liquor with beer to the point where she experienced blackouts. Within three days of her arrest, Daniella tested positive for THC and alcohol. She later tested positive for methamphetamine and THC. The Substance Abuse Assessment noted that Daniella’s son had expressed concern over her drinking, and the assessment foreshadowed that, “without long-term counseling services, her child continues to be at risk of harm.”

Despite acknowledging that Daniella’s behavior would continue to jeopardize Mateo, CYFD’s response was tepid and ineffectual. Similar to its approach during the March 2017 investigation, CYFD temporarily placed Mateo on an informal “safety plan,” relying upon the care of his aunt, Blanca C. But CYFD made a significant error—it never followed up on its safety plan and allowed the investigation to remain open for 116 days past the closure deadline without any oversight of Daniella’s behavior.

The NMDNJ interviewed Blanca, who stated that she contacted CYFD after Daniella “disappeared” for months without availing herself of services to improve her parenting. In November 2017, Blanca expressed her frustration when making a report to CYFD, exclaiming that “the state needs to do their job and terminate [Daniella]’s parental rights.”

¹⁸⁴ A Safehouse interview is a trauma-informed, developmentally appropriate forensic interview conducted by a professional to collect information from a child regarding abuse or neglect.

Daniella resurfaced in January of 2018. CYFD placed Mateo back into her custody immediately, without ensuring that Daniella received the treatment and parental instruction the Department earlier acknowledged was sorely needed. The investigation was closed on January 8, 2018. Even with two substantiated reports of abuse and neglect, CYFD again failed to prioritize Mateo's health and safety.

Daniella's issues continued into mid-2018. In May 2018, [CYFD received two separate reports](#) alleging that Daniella was continuing to use narcotics and abuse Mateo. The source of the first report on May 2, 2018 was a former roommate of Daniella who observed Daniella and her new boyfriend, Tomas S. Sr., "shooting up meth in the bathroom." Daniella was four months pregnant at the time of the report. The source further reported that Daniella "whooped" Mateo a few times on his lower back and butt area. A second CPS Intake Report was also submitted by Blanca on May 21, 2018. She reported to CYFD that Mateo was not being properly fed, and when he did get food, he only ate junk food.

Despite unsubstantiating one report and substantiating the other, CYFD conducted an incomplete investigation in both instances. While both Daniella and Mateo were interviewed, CYFD made no effort to speak with other individuals with pertinent information (collateral contacts), or the sources of either report. CYFD did not require Daniella to take a drug or alcohol test, despite current allegations of methamphetamine use while pregnant, supported by a recent Substance Abuse Assessment documenting chronic substance addiction. CYFD only completed a single home visit during the summer. But this was a hollow gesture, as Mateo was staying with his biological father's family in Mexico over the summer. CYFD closed the investigation without ensuring Daniella received services or that Mateo would be protected moving forward.

On November 14, 2018, CYFD opened another investigation. Daniella had given birth to a second child, Noah S., who was born exposed to methamphetamine and THC. According to FACT narratives from CYFD, Daniella denied knowingly using methamphetamine and said that she received a "weed brownie from a friend that may have been laced with methamphetamines."

Despite the prior substantiated reports for substance use and physical abuse of Mateo, CYFD placed Noah on a safety plan in the care of Daniella's cousin, Chris L. According to [CYFD case notes](#), Chris contacted CYFD in early January 2019, informing them that Daniella and Noah had left his home and he did not know where they went. Chris had attempted to call police so that they could help find Noah, but because CYFD had not provided Chris with a copy of the safety plan, police would not intervene further.

CYFD allowed Noah to remain in Daniella's care unsupervised, informing Chris that the safety plan was no longer valid and that CYFD would continue offering support to Daniella. A CYFD investigator told Chris, "the [D]epartment has to make efforts to work with the family and prevent the children from being removed from the home." This response was both irresponsible and disingenuous. While CYFD is required to make reasonable efforts to prevent a child's removal, nothing in New Mexico law or CYFD policy obligates the Department to offer unlimited chances to a parent absent any accountability or effort, particularly when a child is at risk of imminent harm.

Daniella tested positive for methamphetamine twice in January 2019. Although CYFD referred her to the Department's In-Home Services program, she declined to participate and continued using narcotics. CYFD made no effort to remove either Noah or Mateo from Daniella's custody, allowing her reckless behavior around her children to go unchecked.

On February 3, 2019, CYFD received another CPS Intake Report alleging that Daniella physically abused then 10-year-old Mateo. A neighbor told CYFD that she observed Daniella hitting Mateo on the back of the head, yelling at him, using profanity, and throwing him out of the home. Daniella was overheard demanding Mateo look for a dog that had left the property, telling Mateo that she wanted him to leave and for him to "be gone like the dog." Mateo told law enforcement that when police officers were knocking on the door, his mother shoved underwear into his mouth to keep him quiet. Mateo told an APD sergeant that "he doesn't feel safe" with Daniella:

Acting Sergeant Hailey Mehus went to talk to [REDACTED]. [REDACTED] disclosed to her that when law enforcement was knocking on the door [REDACTED] shoved underwear into [REDACTED]'s mouth to keep him quiet. [REDACTED] stated [REDACTED] made him lie down on the carpet and was sitting on top of him so he couldn't get up. [REDACTED] stated [REDACTED] was also pinning him down by the neck and telling [REDACTED] that he was going to get her in trouble and that she would never see [REDACTED] and [REDACTED] again. [REDACTED] had fresh nail marks on his neck - [REDACTED] stated that this was from [REDACTED] holding him down. Source advised the underwear that [REDACTED] said [REDACTED] shoved into his mouth was found and was wet - consistent with being shoved into someone's mouth. [REDACTED] had no other visible marks or bruises. [REDACTED] stated his neck was hurting and he had a headache.

Given the circumstances, responding police officers were concerned for infant Noah's safety and welfare. According to [FACT narrative notes](#) entered by CYFD, police officers reported that Noah had to be bathed at the hospital because he was encrusted with dirt and smelled badly. Noah had reportedly not been bathed in the last week. Noah had eczema on his stomach, redness and irritation where his skin creased, nail-like red marks on both sides of his neck, and bruising to both his ear lobes. Both Mateo and Noah showed clear signs of physical abuse and neglect.

CYFD held a [FCM](#)¹⁸⁵ with Daniella on February 5, 2019. During the meeting, CYFD recorded several ongoing safety risks and concerns. Daniella had not engaged in substance abuse treatment since her last protective services involvement, was not forthcoming about her addictions, and had refused a recent drug test. CYFD further noted, “the behavior of mom places the children in danger” and highlighted that 10-year-old Mateo was caring for his infant brother alone. The Department did not have contact information for either Mateo or Noah’s biological fathers. Each of these factors presented as clear warning signs well in advance of this February FCM. Finally, for the first time after four substantiated reports of physical abuse, neglect, and rampant narcotics use that endangered her two children, CYFD removed Noah and Mateo from Daniella’s custody. CYFD put Daniella on a treatment plan that included parenting and anger management classes along with substance abuse counseling.

After removing the children from Daniella’s custody, CYFD learned that Daniella was pregnant with another child. Mateo expressed concern to CYFD that his unborn brother would soon be placed in the same danger:

██████████ does not want to be separated from ██████████ and he is devastated that ██████████ is pregnant again, stating, “she will do to him what she did to me.” The baby is another boy.

On October 19, 2019, Daniella gave birth to a third child, Tomas S. Jr. CYFD received a report that Tomas Jr. was born exposed to marijuana. Daniella admitted to using marijuana consistently throughout her pregnancy. CYFD “screened-out” the report, choosing not to investigate further.

Despite the additional stress and responsibility following the birth of another child, CYFD sought to quickly return one-year-old Noah to Daniella’s home. At a FCM held December 10, 2019, CYFD’s county office manager determined that Noah would be returned to Daniella and Tomas Sr. on a trial home visit.

On December 17, 2019, exactly one week after the most recent FCM, CYFD received another [CPS Intake Report](#) for an incident that occurred the day before. The report noted that Daniella’s eight-week-old child Tomas Jr. was in the hospital with multiple skull fractures. Daniella initially blamed Tomas Sr., [as she told CYFD investigators](#) that Tomas Sr. fell asleep feeding Tomas Jr., and that the child must have received injuries to his skull after Tomas Sr. dropped him.

Daniella’s explanation for Tomas Jr.’s injuries was contradicted by medical evidence. Dr. Leslie Strickler at UNMH performed a Child Abuse Response Team (CART) examination

¹⁸⁵ FCMs are designed to increase a family’s participation with the protective services division in making decisions about their children’s safety and case plans. CYFD, [Protective Servs. General Policies](#) (8.8.2 NMAC) PR 20, § 5.

on Tomas S. Jr.¹⁸⁶ Dr. Strickler's exam revealed significant impact trauma to Tomas Jr.'s head and cervical spine, facial bruising, injury to the mouth, and fractures of the ribs, wrist, and left tibia. Dr. Strickler determined that Tomas Jr.'s presentation was consistent with physical abuse and that "no adequate traumatic explanation for any of the appreciated injuries has been provided by [the child's] caretakers":

ASSESSMENT:

██████ is an 8-week-old male who presented to care with acute onset swelling of the left scalp. Comprehensive evaluation has identified significant impact trauma to the head including left scalp hematoma with underlying left parietal skull fracture and intracranial and intraparenchymal hemorrhage as described above. Imaging also demonstrates cervical spine injury. Physical examination has identified facial bruising, right subconjunctival hemorrhage, oral trauma including transection of the superior labial frenulum bruising of the sublingual frenulum, and bruising of the upper lip. Skeletal imaging has identified multiple fractures in various states of healing involving the ribs, wrist and possibly left tibia. ██████ has Hypovitaminosis D which in isolation without radiographic signs of rickets does not predispose ██████ to numerous fractures.

No adequate traumatic explanation for any of the appreciated injuries has been provided by ██████'s caretakers. ██████ does not possess the strength, coordination or mobility to self-inflict any injuries of significance. There is not indication in ██████'s medical history, physical examination, laboratory or imaging studies of predisposition to impact head trauma, oral injury, and multiple fractures. This presentation is diagnostic of physical abuse. Given the healing status of many of ██████'s fractures, this indicates that injury has occurred on at least 2 different occasions as head injury and oral injury are relatively acute. Failure of caretakers to protect ██████ from recurrent physical abuse indicates physical neglect. There is family history of prior physical abuse, neglect, and emotional abuse in ██████'s sibling.

In April 2021, Daniella and Tomas Sr. were both criminally charged for child abuse resulting in great bodily harm based on Tomas Jr.'s injuries. Tomas Sr. accepted a plea agreement and became a witness against Daniella in the state's criminal prosecution. During an interview with the District Attorney's office, [Tomas Sr. told prosecutors](#) that when he fell asleep, Tomas Jr. was in Daniella's care. Between 30 and 45 minutes later, Daniella woke Tomas Sr. up and told him Tomas Jr. had a bump on his head. Tomas Sr. told prosecutors that Daniella was worried about going to the hospital because she knew that CYFD would take her kids away. Tomas Sr. [further described to prosecutors](#) his account of how Daniella may have caused Tomas Jr.'s fractures. Tomas Sr. believed the fractures could have been due to Daniella's actions when frustrated. Tomas Sr. recalled that she treated Tomas Jr.'s discomfort "as a burden to her."

¹⁸⁶ CYFD's notes incorrectly refer to a "Dr. Strickland." The examining physician was Dr. Leslie Strickler, a Professor of Pediatrics and medical director of CART, a team that conducts medical evaluations of children who are alleged victims of abuse or neglect.

Dr. Strickler also testified against Daniella at trial. Dr. Strickler told the jury that Tomas Jr.'s head injury was caused by blunt force trauma to the head. Dr. Strickler explained that the blunt force trauma resulted in a significant brain injury. Dr. Strickler ruled out any explanation that Tomas Jr. was dropped and fell on his head. In December 2024, a Bernalillo County jury determined that Daniella was guilty of child abuse causing great bodily harm. Daniella was [sentenced to 18 years](#) in prison.

CYFD's hurried insistence to reunify Daniella and her children created circumstances for the children to experience more trauma. By the time Tomas Jr. was abused in December 2019, CYFD had substantiated six abuse and neglect reports against Daniella for her treatment of Mateo and Noah. CYFD was aware that Daniella had physically abused Mateo by hitting and kicking him, throwing him down, sitting on top of him, and shoving underwear in his mouth to keep him from talking to police. CYFD was aware of Daniella's ineffective approach to her substance abuse problem. Yet CYFD failed to remove Daniella's children after it became apparent that she was not amenable to drug treatment or counseling. Even a cursory review of Daniella's lengthy CYFD history would have demonstrated her near-absolute refusal to participate in treatment or other services. In Tomas Sr.'s [statement to prosecutors](#), he alluded to Daniella's continued narcotics use despite a CYFD-mandated treatment plan:

"She mentioned she was doing fentanyl and cocaine with the neighbors downstairs . . . [w]hich is confusing me because we're working a CYFD program, and she found a way to do things on a Friday so that she could pass her drug test on a Monday."

In October 2021, Daniella made the decision that CYFD should have made long before—she voluntarily relinquished her parental rights to Noah and Tomas Jr. Importantly, CYFD did not move to terminate Daniella's parental rights to her eldest son, Mateo.

During this period, CYFD allowed Mateo to live with his biological father, Gilbert, in Mexico. However, Mateo returned to the United States in August 2022 after his father asked Blanca (maternal aunt and prior safety monitor) to retain custody of Mateo. An [APD police report](#) from August 3, 2022 shows that Daniella tried to regain physical custody of Mateo, but Mateo told police that he did not want to return to Daniella because of the abuse he suffered in the past. The APD officer told Daniella that he would not place Mateo back in her care. Despite law enforcement's explicit concerns and evident safety risks, CYFD still chose to return Mateo to Daniella's custody.

While under criminal indictment for her abuse of Tomas Jr.—and after her relinquishment of parental rights over both Tomas Jr. and Noah—Daniella gave birth to two

more children in 2022 and 2023. Ava W. was born in January 2022, and Sofia W. was born in March 2023. Predictably, Daniella's abuse and neglect of her children continued.

Similarly, CYFD's endorsement of Daniella's actions persisted. On August 7, 2022, CYFD received a [CPS Intake Report](#) accusing Daniella of drinking alcohol while driving with her daughter Ava in the vehicle. Daniella was in a verbal dispute with her new boyfriend and Ava's (and later Sofia's) biological father, David W. CYFD interviewed both Daniella and David, and both admitted to consuming alcohol and having a verbal altercation in Ava's presence. CYFD did not require Daniella or David to engage in substance abuse counseling, parenting classes, or to submit to random drug or alcohol testing. Instead, CYFD closed the investigation and found the allegations to be unsubstantiated.

On May 30, 2024, CYFD received an [abuse and neglect referral](#) involving Sofia. Sofia was brought into the emergency room after Daniella reported that Sofia jumped off the couch and tripped over an extension cord, injuring her jaw. CT scans of Sofia's jaw showed multiple fractures in her lower jaw and a laceration to her bottom lip. The surgeon reported that Sofia would likely have a lifetime jaw deformity and would need to eat only pureed foods for weeks due to her inability to chew. The surgeon also opined that this injury could not have happened from Sofia falling off the couch. When interviewed by CYFD, Daniella and David both maintained that Sofia's fall was an accident.

A CART examination of Sofia was conducted by Dr. Karen Campbell. Dr. Campbell explained the results of the CART exam to CYFD, Daniella, and David during an FCM on June 4, 2024. Dr. Campbell told Daniella and David that given the severity of Sofia's jaw fractures, her injuries could not have come from falling off the couch. Dr. Campbell also raised alarms regarding the children missing several appointments with their primary care physician. CYFD documented Dr. Campbell's concerns:

Dr. Campbell explained that despite their explanations, it still is not consistent with the severity of the fractures in [REDACTED] jaw. Dr. Campbell tried to explain that the location and multitude of fractures would have to be a much larger force to cause the injuries. Dr. Campbell inquired about the doctor visit [REDACTED] had with Dr. Shultz today. [REDACTED] stated Dr. Shultz did inform the family that [REDACTED] would have had to obtain her injury from a fast force or hard force to cause multiple fractures to her jaw. Despite 2 doctors now telling the parents that [REDACTED] would have had to endure a much larger impact than a fall from a couch, the parents continued to state the injury was accidental. Dr. Campbell also added that [REDACTED] and [REDACTED] have missed several of their doctors' appointments with their primary care physician (PCP). Dr. Campbell stated that it was documented by their PCP that there were many efforts to reach out to the family and reschedule appointments, which were successful, but concerning in the sense that the children are still not up to date and have multiple missed appointments documented. [REDACTED] explained that she has a good relationship with Dr. Christopher Roveto and the office since that's where she has been taking her children from the start, but since her pending investigation with the Department concerning her last child, she has fell behind on appointments. She stated that she and paternal grandmother, [REDACTED], were planning to schedule [REDACTED] 12-month checkup and [REDACTED] 2-year checkup together, and that [REDACTED] stated that she planned to put her two grandchildren with the same doctor so that she and [REDACTED] can do all the appointments together. Dr. Campbell also stated that she would

Notwithstanding, CYFD initially planned to allow both Sofia and Ava to remain in Daniella and David's legal custody while on a safety plan with David's parents, with supervised visits by Daniella and David permitted. However, on June 10, 2024, CYFD ultimately filed a petition to remove Sofia and Ava from their parent's custody. This belated decision was prompted by law enforcement's urging and concerns over Daniella's "significant CYFD history" and her children's "ages, vulnerabilities, and inability to self-protect." CYFD's petition cited the following:

43. It would be contrary to the children's welfare to return home due to the lack of an appropriate caregiver willing or able to provide a safe environment. Safety threats identified in the home are physical abuse of [REDACTED] that has resulted in bone fractures and the caregiver's explanation of the injury is inconsistent with the severity of the injury. Due to the children's ages, vulnerabilities, and inability to self-protect, the children are unable to communicate how this injury was obtained making [REDACTED] and her sibling more susceptible to further injury. The children's mother has significant CYFD history that is patterned and includes risk factors such as a history of substance use. In addition, this family has received multiple, intensive services and continue to come to the Department's attention for severe injuries. Despite reasonable efforts and active efforts to prevent removal, there is no appropriate caregiver, therefore, the Department is requesting that [REDACTED] and [REDACTED] remain in legal custody.

While the decision to seek legal custody of Sofia and Ava was supported by the totality of Daniella's history with the Department, CYFD's removal decision appeared only temporary. In an [Initial Assessment Plan](#) created as part of Sofia's abuse and neglect case, CYFD continued to recommend reunification with Daniella.

In total, [CYFD received 14 reports of abuse and neglect involving Daniella.](#) CYFD initiated 12 investigations and screened-out two referrals. Not one of Daniella's five children was spared from her abuse and neglect. Despite clear warnings from Daniella's family, law enforcement, and medical professionals, CYFD continued to prioritize reunification over the safety of Daniella's children. CYFD's actions constituted [multiple violations of New Mexico law and CYFD policy.](#)

Dr. Moyer also reviewed Daniella's case history, opining that in several abuse and neglect investigations, CYFD neglected to thoroughly interview collateral contacts with information about the allegations. For example, in each of the investigations on April 10, 2015, May 21, 2016, and May 21, 2018, CYFD did not attempt to speak with relevant

witnesses. The lack of robust investigation prevented the Department from performing a comprehensive family assessment.

Dr. Moyer also found that CYFD often waited well beyond the 45-day deadline to formally close their investigations. Investigations from March 10, 2017, July 31, 2017, May 21, 2018, and November 14, 2018, were all closed at least one month after the deadline established by CYFD policy, suggesting a lack of appropriate supervisory oversight. Proper support from supervisors and county office managers are essential, especially for parents with a history of declining services and resources like Daniella. Dr. Moyer's report explains that standard practice is to verify referral engagement before closing an investigation, and proper supervision could have ensured this step had been taken in Daniella's cases. The missed deadlines further indicated a lack of ongoing client contact, preventing a current evaluation of safety and risk prior to investigation closing. Daniella's protective services history makes one fact undeniable: her children endured extensive, preventable abuse as a result of CYFD's persistent lapses in oversight and intervention.

5. Case Study: "Marissa E." and "Cameron F. Sr."

The case of Marissa E. and Cameron F. Sr. illustrates another example of CYFD's predisposition to prioritize reunification over child safety, even when caregivers demonstrate an inability to ensure safe and stable environments. Marissa and Cameron Sr. are the biological parents of two children: Cory F. (YOB: 2021) and Valerie F. (YOB: 2023). In addition to their shared children, both Marissa and Cameron Sr. each have a son from prior relationships: Marissa is the mother of Ezekiel E. (YOB: 2013), and Cameron Sr. is the father of Cameron F. Jr. (YOB: 2007). As of this report, four-year-old Cory and three-year-old Valerie remain in foster care while CYFD responds without urgency or proper regard to ongoing allegations of parental abuse, neglect, and failure of biological parents to comply with treatment plans.

- a. Cameron Sr. and Marissa have a lengthy history of criminal behavior and CYFD abuse and neglect referrals.*

Both Cameron Sr. and Marissa have an extensive track record with CYFD. According to CYFD's FACTS data, between their four combined children, Marissa and Cameron Sr. were the subjects of 17 abuse or neglect investigations, of which 11 were substantiated. Between September 2014 and May 2025, Cameron Sr. has been investigated by CYFD for abuse and neglect 11 times, including five investigations that were substantiated. In several instances, Cameron Sr. temporarily lost custody of his older son Cameron Jr.¹⁸⁷ Marissa has been

¹⁸⁷ Cameron Jr. was placed in CYFD custody on a 48-hour hold in September 2014, November 2016, and March 2021.

investigated by CYFD six times between October 2013 and January 2023, all six of which were substantiated. Substantiated reports for these parents include prenatal and postnatal drug exposure, and inadequate supervision.

Marissa and Cameron Sr. also have substantial criminal records. Collectively, Marissa and Cameron Sr. have been arrested over 50 times for various crimes, including offenses that directly endangered their children. Between January 2014 and October 2024, [Marissa was arrested 26 times](#) for repeated shopliftings, property crimes, and drug possession. Marissa has two felony convictions from 2015 and 2019. Between May 2011 and August 2023, [Cameron Sr. was arrested over 20 times](#). He has eight felony convictions, including drug trafficking and possession, receipt of stolen motor vehicles, and possession of a firearm by a felon.¹⁸⁸

Prior criminal conduct by Cameron Sr. and Marissa that posed significant risks to their children's health and safety included:

- May 19, 2013—APD officers responded to an apartment in southeast Albuquerque in reference to an alleged kidnapping. Two male subjects told police that Cameron Sr. accused them of stealing his heroin and cash. In response, Cameron Sr. punched the men in the face, hit one with a whisky bottle, and pointed firearms at them while threatening to kill them. Six-year-old Cameron Jr. was present at the apartment.
- [November 7, 2016](#)—APD's gang unit tracked a stolen vehicle driven by Cameron Sr. and Marissa to an apartment in Albuquerque. Upon entering the apartment, Cameron Sr. and Marissa were taken into custody. There, officers found nine-year-old Cameron Jr. in close proximity to narcotics and paraphernalia. CYFD was notified of the danger to Cameron Jr. The APD detective noted:

██████████. A check through NCIC and MVD, verified he had two outstanding felony warrants for his arrest. Detective Porter was talking to ██████████ and allowed her to get shoes from within the apartment and he noticed several needles lying throughout the apartment and a white crystal type substance, which appeared to be "Meth" lying on the floor. ██████████ was found to have misdemeanor warrants. Detective Porter collected the white crystal substance suspected to be "Meth" 1.50 gm, a black substance suspected to be "Heroin" 3.00 gm, and paraphernalia which were tagged it into evidence. ██████████

- [March 8, 2021](#)—13-year-old Cameron Jr. reported to law enforcement that Cameron Sr. had struck him, used drugs in his presence, and previously threatened to kill him. Cameron Jr. also disclosed that Marissa witnessed the abuse and had previously hit him herself.¹⁸⁹ Officers observed firearm ammunition and drug paraphernalia in plain view. CYFD was notified. The police report stated:

¹⁸⁸ Both Marissa and Cameron Sr. are habitual criminal offenders under New Mexico law. Any sentences for subsequent convictions can therefore be enhanced. See NMSA 1978, §§ 31-18-17.

¹⁸⁹ Marissa was in her early stages of pregnancy with Cory during this incident.

NARRATIVE

On 3/9/2021 at approximately 2245 hours, I was dispatched to [REDACTED] regarding a family dispute. The caller, later identified as 13 year old [REDACTED], advised his dad, also identified as [REDACTED], had hit him and he could no longer feel his arm. He advised his father does this to him all the time and had left the apartment. While in route [REDACTED] stated that his father had multiple guns in the house, does drugs in front of him, and has threatened to kill him before. He also mentioned that he wanted to be taken to child protective services and his dad would kill him if he found out he called. I arrived on scene but was not getting an answer at the door; however, I observed a teenage male in the complex immediately to the east exit and come down the stairs. He confirmed he was [REDACTED] and we relocated to [REDACTED] 7. Upon entering and clearing the apartment finding no one else inside, I immediately observed that the residence was in disarray. There were piles of clothing on the floor in multiple areas, ammunition laying on the living room floor, a large bag of ammunition and loaded magazines, and drug paraphernalia including glass pipes and syringes. There was also old food on the dinner table and the floors and other surfaces were unclean. [REDACTED]

- [March 27, 2021](#)—Isleta police arrested Cameron Sr. on an outstanding felony warrant. Inside his vehicle, officers seized drug paraphernalia (pipes, lighters, foil, scales, and packaging baggies), over 2 ounces of methamphetamine, an ounce of heroin, numerous fentanyl pills, a loaded 9mm firearm, and a sawed-off rifle.

b. Cory and Valerie suffer serious neglect necessitating removal from parental custody.

In November 2021, Cory F. was born exposed to fentanyl and methamphetamine. While at the hospital after Cory's birth, [Marissa assaulted and battered two healthcare staff](#), reportedly telling the nurses, "Let me go and get my bags so I can smoke more fentanyl." A report of this incident was made to CYFD. Upon being discharged from the hospital's NICU, Cory was placed on a brief CYFD safety plan with his aunt, before returning to live with Cameron Sr. and Marissa. Cory required intensive medical care and continues to experience significant developmental challenges.

On July 29, 2022, Cory suffered a life-threatening event while in his parent's care. On that date, law enforcement and paramedics responded to a call of an unresponsive child due to suspected fentanyl exposure. Upon arrival, first responders found eight-month-old Cory not breathing and lying face-down on a bed. It took a dose of Narcan—a drug used to reverse opioid overdoses—to revive him back to life. Cory was then transported to UNMH's pediatric emergency department.

According to [APD's report](#), Cory's vital signs necessitated three additional intravenous doses of Narcan before he became fully responsive. When asked how the overdose happened, Marissa told law enforcement that she left her apartment "for just a little bit of time" and when she returned, she found Cory unconscious. Cameron Sr. stated that he was not at the apartment during the event. APD Crimes Against Children Unit (CACU) detectives [executed a search warrant](#) at Marissa's apartment, and found the apartment in disarray. They seized suspected narcotics, a loaded syringe, pills, and other paraphernalia, including a pipe and multiple burnt foils.



Figure 12. Photos from APD investigation on July 29, 2022. Clockwise from top left: Cluttered room and crib; burnt foil, pipe, and loaded syringe; white powder substance; and baggie of pills.

As [documented in the APD detective's report](#), a UNMH CART physician noted that Cory arrived extremely dirty, with “dirt all over his body, under his diaper, under his penis, behind the ears, arms, face and feet.” A toxicology screen confirmed that Cory had fentanyl in his system. Citing Marissa’s history of drug use, the physician documented “significant concerns for lack of supervision and physical neglect, including fentanyl ingestion, and medical neglect.” Upon his discharge from the hospital, Cory was taken into state custody.

A follow-up CART exam was performed on August 22, 2022. Medical providers expressed concern that Cory’s parents had created an unsafe environment, leaving Cory susceptible to inadequate supervision, malnutrition, and potential physical abuse:

There is a high level of concern for active substance use disorder by parents. Illicit drugs and illicit drug environments are hazardous to children in many ways. These children are at risk of suffering accidental injuries due to inadequate adult supervision, and they may suffer malnutrition or other effects of physical neglect because their caregivers are too impaired to sufficiently care for them. Children exposed to drugs are also at increased risk of sexual and physical abuse when caregivers are under the influence of mind-altering substances. Toddlers and older children living in illicit drug environments are at risk of inadvertent exposure to or ingestion of drugs from residues and paraphernalia.

Less than six months after Cory’s near-fatal drug exposure, Marissa and Cameron Sr. had another child, Valerie F. Like Marissa’s prior two births, Valerie was also prenatally exposed to dangerous drugs. Valerie was taken into state custody at birth and placed with

Marissa’s cousin, Brianna B. Since January 2023, both Cory and Valerie have been in CYFD custody and living with foster families.

c. Reunification efforts continue despite ongoing allegations of abuse, neglect, and treatment plan noncompliance.

As Cory and Valerie’s legal custodian, CYFD is required to ensure placements that protect their health and safety. Yet, according to what foster parents relayed to the NMDOT, CYFD has repeatedly overlooked Cameron Sr. and Marissa’s lack of accountability and plan compliance, to the detriment of Cory and Valerie. In the time since Cory and Valerie were taken into CYFD custody (August 2022 and January 2023 respectively), Marissa and Cameron Sr. have been engaged with their children to different extents, and at different times. Nevertheless, both have demonstrated a clear unwillingness to provide a consistently safe and supportive home for their young children.

i. Marissa E.:

After Cory’s entry into state custody in August 2022, supervised visits were arranged with his parents. Marissa attended these meetings sporadically, and was often observed “dozing off” or uninterested during those visits. Strangely, despite an extensive criminal history involving narcotics and each of her children being born drug-exposed, CYFD failed to require Marissa to undergo drug testing as a condition of her visitation.

By January 2024, Marissa had ceased all visits with Cory and Valerie. Although no longer in contact with CYFD, court records indicate that Marissa continued to use drugs. Upon Marissa’s indictment on child abuse charges on June 10, 2024 (for her role in Cory’s opioid exposure in July 2022), the court ordered her to abstain from drug use, and to submit to drug testing. A [noncompliance report](#) submitted to the judge indicated that Marissa had tested positive for methamphetamine and fentanyl in July 2024, and missed a required urinalysis in August 2024:

Previous Violations/Results

07/26/2024 Violation-Positive Drug Screen Meth/Amphetamines, Methadone, THC, Fentanyl. 08/27/2024 Violation-Positive Drug Screen UA no show.

Marissa’s continued noncompliance led the court to issue a warrant for her arrest. She was [arrested on October 31, 2024](#), and officers seized methamphetamine and fentanyl from her pocket. On August 19, 2025, Marissa pled guilty to child abuse and possession of drug paraphernalia, and on October 1, 2025, was sentenced to 15 months in prison, followed by three years of supervised probation.

ii. Cameron F. Sr.:

Like Marissa, Cameron Sr. initially attended CYFD supervised visits with Cory beginning in August 2022. Cameron Sr.'s participation was also inconsistent, and he was frequently seen falling asleep, signaling a lack of engagement and interest. By November 2022, Cameron Sr. abruptly stopped all visits with Cory without providing any explanation.

On August 25, 2023, Cameron Sr. was [arrested by APD](#) on a probation violation warrant from a prior felony conviction. During the arrest, officers found fentanyl, cocaine, and a [firearm](#). Cameron Sr.'s probation was revoked, and he was incarcerated.¹⁹⁰ Cameron Sr. was released from jail in February 2024, and despite his recent incarceration and prior abandonment of visits, CYFD immediately reinstated supervised visitation. Cameron Sr.'s conduct during visits reflected minimal progress from his prior pattern of neglect and disregard. In May 2024, Cameron Sr. attended a supervised visit with Cory and Valerie while under the influence of methamphetamine and opioids.

Notwithstanding evidence of recent drug use, CYFD allowed Cameron Sr. to begin unsupervised visits with Cory and Valerie in December 2024. During these unsupervised visits, Cory and Valerie were left alone with Cameron Sr., and their 17-year-old half-brother, Cameron Jr. In addition to concerns about Cameron Sr.'s parenting, Cameron Jr. also posed significant risks due to his juvenile record. At the time unsupervised visits began, Cameron Jr. had been arrested or referred for prosecution on charges including aggravated battery, possession of stolen vehicles, and shooting at an occupied vehicle.

By March 2025, both Cory and Valerie began disclosing to their respective foster parents that Cameron Sr. was abusing them during their unsupervised visits. Between March 25, 2025, and May 8, 2025, Cory and Valerie disclosed six distinct incidents of abuse, of which four separate reports were made to CYFD. These incidents included:

- March 25, 2025—After an unsupervised visit with Cameron Sr., three-year-old Cory told his foster mother that “daddy hit Valerie,” then two years old. A bruise was observed on Valerie’s right wrist, and a SCI report was made. Cory repeated this disclosure on at least three additional occasions.
- April 8, 2025—Cory disclosed to his foster mother that “daddy hit me” and then pulled the covers over his head and refused to talk.
- April 24, 2025—Cory disclosed that “daddy hit me in the car.” Cory had a red mark on his left arm. A SCI report was made with CYFD.

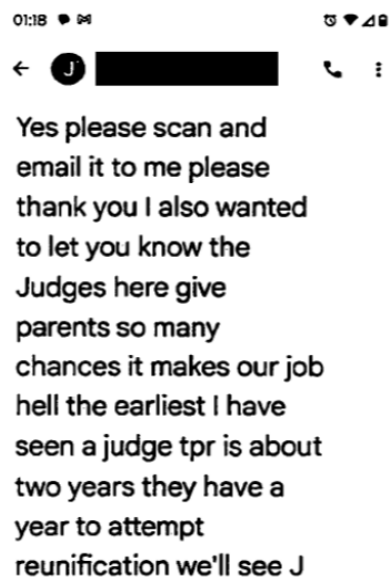
¹⁹⁰ In the 42 months since Cory’s removal into state custody (August 2022 to January 2026), there was only a three-month overlap where both Cameron Sr. and Marissa jointly attended supervised visits with Cory (August to November 2022).

- April 29, 2025—Cory returned from an unsupervised visit aggressive and dysregulated, and stated “daddy hit me.” Cory reiterated this statement to a child psychiatrist at a pediatric urgent care.
- May 1, 2025—Valerie disclosed to her foster mother that “daddy hit my cheek.” A SCI report was made to CYFD, and this abuse was disclosed to Valerie’s PPW during their scheduled home visit.
- May 8, 2025—Cory returned from an unsupervised visit with a “red backside” and marks on his right shoulder. Cory also disclosed “daddy hit Cory’s cheek.” On May 12, 2025, Cory also disclosed this event to his daycare teacher, who noted their intent to file a SCI report to CYFD.

Upon receipt of these frequent and corroborated disclosures by Cory and Valerie, CYFD’s concerns should have immediately centered on the safety of the children. Instead, CYFD took issue with what they believed to be collusion between Cory and Valerie’s foster parents in making the SCI reports. CYFD stated to Cory’s foster mother that their “reports just sound so similar.” Cory’s foster mother told the NMDNJ that she felt discouraged from making future abuse or neglect reports to SCI based on CYFD’s treatment and insinuations.

Given Cory and Valerie’s corroborated disclosures of abuse, and in light of Cameron Sr.’s violent criminal history, CYFD’s skepticism toward the foster parents’ SCI reports was beyond unreasonable. It is highly unlikely that then three-year-old Cory and two-year-old Valerie conspired to fabricate consistent accounts of abuse. The far more plausible explanation is that Cameron Sr. posed a serious risk, and the children’s accounts were consistent because they both experienced the same things. CYFD was aware of and obligated to address those risks to Cory and Valerie’s safety and well-being. CYFD policy expressly permits visits to be terminated at any time when the PPW determines the safety of the child is threatened in any way.¹⁹¹

Rather than halting or restricting visits, or requiring immediate supervision, CYFD allowed Cameron Sr. to continue unsupervised contact with his two young children. The CYFD PPW’s only response to the foster parents’ repeated concerns about the trauma Cory and Valerie experienced during visits was to note the difficulty of securing a termination of parental rights, blaming the Children’s Court judges for giving “parents so many



01:18 [status icons]
 [back arrow] [profile icon] [redacted name] [phone icon] [menu icon]
 Yes please scan and
 email it to me please
 thank you I also wanted
 to let you know the
 Judges here give
 parents so many
 chances it makes our job
 hell the earliest I have
 seen a judge tpr is about
 two years they have a
 year to attempt
 reunification we'll see J

Figure 13. Text message from CYFD PPW to Cory’s foster mother.

¹⁹¹ CYFD Permanency Planning Proc. PR 19, § 6.1 (“Safety of Child”).

chances.” Although Cory and Valerie’s permanency plans had shifted to adoption during this period, CYFD still worked to secure Cameron Sr.’s compliance to move toward reunification.

On June 4, 2025, the Children’s Court held a permanency hearing to discuss next steps in Cory and Valerie’s case. Cory’s foster mother was told in advance of this hearing that CYFD would be seeking a reversion of Cory and Valerie’s adoption permanency plan back to reunification with Marissa (incarcerated) and Cameron Sr. That hearing could not fully proceed, however, because the assigned PPW failed to have a report submitted to the court for consideration.¹⁹² To make matters worse, Cory’s foster mother told the NMDOJ that a CYFD permanency supervisor misrepresented key facts to the court, creating a misleading impression that Cameron Sr. was significantly more involved in his children’s lives than was true. According to Cory’s foster mother, Cameron Sr. missed over 50% of his visits since early April and never attended any medical or behavioral appointments with Cory or Valerie. The court rescheduled a full hearing for August 27, 2025, to address outstanding issues.

On August 27, 2025, CYFD concurred that visits between Cameron Sr., Cory, and Valerie would be supervised moving forward. However, only one day later, the same permanency supervisor that misled the court at the prior hearing authorized an unsupervised visit in violation of the court’s order.

By the end of 2025, the Department was actively pursuing a trial home visit and eventual reunification between Cameron Sr. and Cory. At the same time, CYFD is supporting foster parent Brianna B.’s guardianship of Valerie, citing Cameron Sr.’s admission that he can only care for Cory and lacks a bond with Valerie. CYFD appears unconcerned by Cameron Sr.’s intent to selectively parent his children and his expressed indifference toward Valerie. The reunification efforts between Cory and Cameron Sr. (and presumably Marissa upon her release from prison) continue unabated, despite federal and state law mandating CYFD seek termination of Cameron Sr. and Marissa’s parental rights once their children remained in foster care for 15 of the prior 22 months. CYFD has been in violation of this requirement for over two years.

Cory’s foster mother communicated her deeply held concerns to the NMDOJ about CYFD’s reckless approach, and her fear for Cory’s safety. She stated:

“If Cory is returned to Cameron [Sr.], Cory will end up dead. Cameron [Sr.] is extremely dangerous and struggles with addiction and anger management. He has a lengthy criminal history with charges including: child abuse, kidnapping, witness intimidation, drug possession with intent to distribute as well as

¹⁹² Cory’s foster mother told the NMDOJ that CYFD PPWs failed to submit reports to the court on time on at least three occasions, resulting in hearing delays.

multiple other drug offenses. He is unfit to parent and a generic treatment plan imposed by CYFD will not change this fact. Cory struggles with behavioral issues and is a highly active child. I hold a level 2 license with CYFD and am fully qualified to manage Cory's behaviors, and I find Cory challenging. Given Cameron [Sr.]'s history of child abuse, one tantrum from Cory will surely trigger Cameron [Sr.] and Cory will end up on the front page of the Albuquerque Journal. **We CANNOT have another dead child due to the negligence and reunification at all costs mindset of CYFD.**" (emphasis added)

6. Case Study: "Jane L."

Jane L. had three children with her husband Daniel R.: Santiago R. (YOB: 2017), Isabella R. (YOB: 2024), and Emily R. (YOB: 2025).¹⁹³ Each of Jane and Daniel's three children were exposed to dangerous narcotics in utero. Although each child experienced challenges stemming from Jane's prenatal neglect, Isabella endured an especially difficult infancy. These hardships were compounded by the absence of meaningful support or sound decision-making from CYFD.

In February 2024, Isabella was born extremely preterm¹⁹⁴ and with drug withdrawal syndrome. Isabella's toxicology tests returned positive for cocaine and methadone. [Hospital records](#) indicate that Jane failed to receive prenatal care, and admitted to cocaine use up to the day before delivery. Isabella remained in the NICU for over five months due to numerous medical issues, including: nutritional deficiencies; respiratory failure and pulmonary insufficiency; congenital heart defect and cardiovascular issues; sepsis; developmental delay and neurological deficits; and multiple other conditions.

Following a domestic dispute at the hospital and a [SCI report by Jane's 17-year-old daughter](#)¹⁹⁵ alleging ongoing drug use and physical abuse in the home, CYFD reassessed Jane and Daniel's fitness to retain custody of Isabella. Upon Isabella's discharge on July 18, 2024, CYFD placed her in the care of Daniel's aunt, along with her brother Santiago. Medical records detail the key events and decisions made during Isabella's hospitalization:

¹⁹³ Jane had two other children from a prior relationship, and Daniel had four other children from a prior relationship.

¹⁹⁴ Isabella was born at 25 weeks gestation.

¹⁹⁵ This July 3, 2024, report was made by CYFD's In-Home Services provider after a conversation with Jane's 17-year-old daughter Kellie L. This report was later substantiated by CYFD investigators.

History

No prenatal care. Mother states she did not know she was pregnant. Mother admits to drug use. Family aware of need for NICU admission. 4/30: CYFD report made for illicit drug exposure and lack of parental visitation. 5/1: CYFD at bedside, met with social work. CYFD has cleared parents to take infant home. 5/11-5/13 ONR x2 with parents, provided appropriate care.

7/11-7/12 Parents roomed in overnight after safety plan established. Security called overnight for dispute and MOB escorted off premises. FOB considering restraining order. CYFD reassessing situation.

07/15: Care conference with CYFD. CYFD has determined that infant will not be discharged to parents. CYFD has taken custody of baby.

07/17: CYFD has determined that great aunt ([REDACTED]) will have guardianship.

CYFD's concerns about Jane and Daniel's parental suitability should have been evident well before Isabella's discharge. By the time Isabella was born, Jane was the subject of five prior investigations by CYFD, several of which substantiated abuse or neglect. Additionally, two of Isabella's family members that spoke with the NMDOJ said they called CYFD at least seven times due to concerns with Daniel's caregiving ability. Daniel had an extensive criminal record, including 21 arrests in New Mexico and felony convictions for child abuse, burglary, aggravated burglary with a firearm, fraud, conspiracy to traffic narcotics, and possession of a firearm.

For the majority of the time Isabella and Santiago lived with their great aunt/foster parent, Lucy D., they had weekly two-hour supervised visits with their parents. Isabella and Santiago had specialized medical and psychological needs, which Lucy primarily managed. The NMDOJ interviewed Lucy, who explained that one-year-old Isabella had frequent pediatric follow-ups, including with a cardiologist and neurologist, as well as occupational therapy. Seven-year-old Santiago was engaged in speech therapy and counseling services. Under Lucy's care, Isabella showed significant improvement from her neonatal complications, while Santiago consistently attended school for the first time in his life.

Jane and Daniel rarely fully participated in Isabella's services. Lucy reported that she took Isabella to weekly early intervention appointments intended to involve her parents, but Jane and Daniel frequently arrived late or failed to attend. CYFD would make excuses for the parents' behavior, stating "All parents parent differently. Your parenting is different from theirs."

CYFD was informed that Isabella and her mother were not bonding as they should. Lucy expressed concern that Jane consistently avoided holding, hugging, or showing affection for Isabella—behavior Lucy described as highly abnormal. CYFD also observed this lack of warmth by Jane. In the Department's January 2025 court report, the PPW noted that during supervised visits, Jane "will tend to Isabella, but tends to keep her in the car seat often, or the maternal grandmother tends to her and holds her more often."

CYFD also struggled to complete monthly home visits. The PPW documented the sporadic nature of communication with Jane and Daniel in their notes:

10. Discuss the extent of the client's compliance with the treatment plan:

The department has attempted to meet with Ms. [REDACTED] and Mr. [REDACTED] monthly in their home. The department has only been able to complete a home visit in August 2024 which was the initial meeting between the PPW and then the next home visit was completed on 12-24-24. The PPW several times monthly requested from Mr. [REDACTED] to schedule a home visit and was never responded to or Mr. [REDACTED] stated he would get back with the PPW. Ms. [REDACTED] phone has been disconnected. PPW found out on 12-24-24 that Ms. [REDACTED] phone was reconnected.

In January 2025, Jane and Daniel had another child, Emily. Like her brother and sister before her, Emily was born exposed to drugs. Although Santiago and Isabella were removed from Jane's care due to her drug use and parental deficiencies, those same concerns did not lead CYFD to remove Emily, who inexplicably continued living with Jane and Daniel.

In mid-2025, supervised visits between Isabella, Santiago, and their parents transitioned to unsupervised visits several times a week. Lucy recalled the children returning home dirty and covered in bruises. Isabella's daycare also raised concerns about bruises on her head. Each time the children came back dirty, hungry, or injured, CYFD's PPW was notified.

In early June 2025, CYFD endorsed an extended trial home visit¹⁹⁶ to begin later that month. Lucy again raised serious concerns about Jane and Daniel's ability to care for Isabella—especially with the added demands of caring for six-month-old Emily. She recalled the PPW dismissing her concerns, stating that her opinion didn't matter, and even threatening to move Isabella to another foster home temporarily until reunification. Isabella returned to her parents on June 21, 2025, to begin the trial visit.¹⁹⁷

Isabella was only living full-time with her parents for 42 days when, on August 2, 2025, she died while in Jane and Daniel's care. On that date, APD responded to a call regarding Isabella in distress. Life-saving measures were attempted by EMS but were unsuccessful.

Daniel told APD detectives that when he tried to wake Isabella up that afternoon, she was "acting weird" and non-responsive. He added that Isabella fell off the bed a few days earlier but did not appear to be seriously injured. Jane speculated that Isabella may have aspirated on food stuck in her airway, and attributed the bruising to Isabella tripping during

¹⁹⁶ At the onset of trial home visits, a PPW sees the family in their residence with increased frequency. As the home visits progress, unsupervised visitation increases, encouraging family independence. The appropriate amount of contact with the family is determined by the PPW and supervisor. CYFD Permanency Planning Proc. PR 19, § 13 ("Worker-Family Visits During Trial Home Visit").

¹⁹⁷ At the early June court hearing, Santiago had already been with Jane and Daniel for vacation and was never returned to Lucy. He remained with the family as part of the trial home visit.

a camping trip. Jane later acknowledged that she sometimes throws Isabella on the bed to change her diaper and “may have done it too hard.” In a forensic interview, Santiago stated, “I think my mom killed [Isabella],” and described Isabella being slammed up against a wall. The [autopsy](#) determined that Isabella’s death was a homicide and she died by blunt head trauma. OMI’s pathologist documented Isabella’s injuries:

Autopsy and postmortem computed tomography scans revealed a young child with evidence of lethal injury to the head. There was bleeding between the dura and the skull with swelling and shifting of the brain, bleeding within the retinas, and a cut involving where the upper lip connects to the gums. There was other evidence of blunt trauma to include numerous bruises of the face, head, and neck, along with scattered bruising of the right leg and left elbow.

APD documented that Jane and Daniel’s residence was extremely dirty. Trash covered the floors. Police recovered naloxone, suboxone,¹⁹⁸ marijuana, and drug paraphernalia in the bedroom. Lucy noted other dangers in the residence for a toddler, including a wood-burning stove on the ground and aggressive pit bulls.

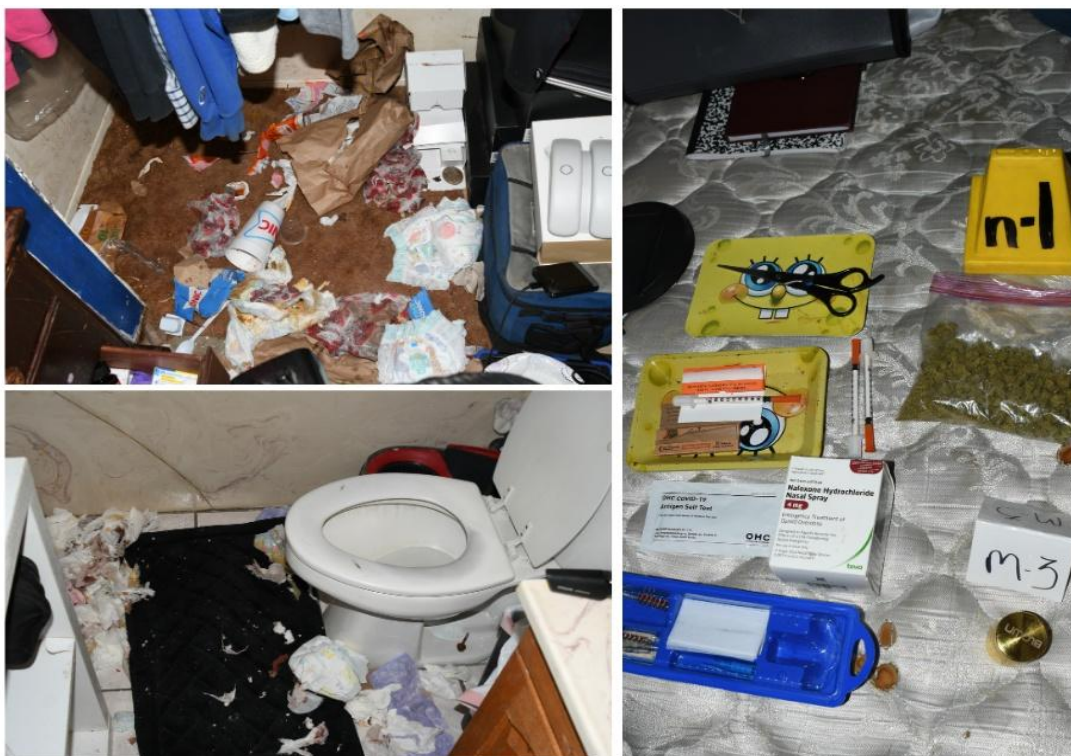


Figure 14. Photos from APD investigation on August 2, 2025. Clockwise from top left: Rotten food and trash in bedroom; syringes, naloxone, and marijuana; and unsanitary bathroom.

On August 6, 2025, Jane was charged with child abuse resulting in Isabella’s death.

CYFD had ample evidence and opportunity to safeguard Isabella. Prior to Isabella’s death, the Department was aware of: (1) Jane’s prior protective services history; (2) Daniel’s

¹⁹⁸ Naloxone is a nasal spray that reverses an opioid overdose. Suboxone is a medication used to treat opioid addiction.

criminal history of child abuse, property crime, drug trafficking, and firearms offenses; (3) three drug-exposed children born within eight years (including one in January 2025); (4) a documented lack of affection and bonding between Jane and Isabella; (5) a repeated inability to contact the parents or conduct monthly home visits; and (6) unsupervised visits that resulted in Isabella returning dirty, hungry, and bruised.

After Isabella’s death, CYFD acknowledged its failures. A PPW involved in Isabella’s case apologized to Lucy, admitting, “We knew she shouldn’t have gone back.” CYFD placed several employees on administrative leave—including an associate deputy director, two county office managers, and Isabella’s PPW and supervisor. The Department conducted an internal investigation that identified procedural deficiencies that led to disciplinary action. The NMDNJ requested email communications between former Secretary Casados, Acting Secretary Sandoval, the Protective Services Division director, and five relevant employees. CYFD’s IPRA custodian failed to produce these readily accessible records.

Lucy warned CYFD against allowing Isabella to live with Jane and Daniel on multiple occasions. She saw what CYFD should have seen—that an expedited reunification was a mistake.

7. Additional Selected Cases Statewide

Case studies discussed thus far in this report are from Bernalillo County, where CYFD’s dysfunction is particularly acute. However, CYFD’s penchant for failing to remove vulnerable youth from dangerous environments is not confined to one county—children throughout New Mexico are suffering the consequences. Four additional examples from different regions of the state demonstrate how missed opportunities for timely intervention have led to preventable harm.

a. Case Study: “Darcy A.” and “Marvin T.” – Grant County

On March 10, 2024, the Grant County Sheriff’s Office (GCSO) was dispatched to a location in Silver City regarding an unresponsive young girl and a boy with “pain in his legs.” Inside, they found Olivia T. dead—just one day after her fifth birthday. Her body was pinned beneath her parents, Darcy A. and Marvin T., who appeared sedated. Olivia’s seven-year-old brother Evan T. was found “slightly breathing” and “struggling to move.”

Upon arrival to the scene, deputies were forced to abandon their patrol vehicles halfway up the driveway due to the large amount of trash on the property. When police entered the home, Olivia’s parents Marvin and Darcy were strewn across a bare mattress on the floor, and Evan sat nearby in a chair amongst the garbage buildup. Deputies noticed “a nose with long blond hair” underneath Marvin and Darcy. Deputies observed that Olivia was

wedged underneath Marvin and repeatedly ordered him to “get up” so they could see Olivia. Marvin was so impaired that he initially did not move or appear aware of the deputies’ orders. When Marvin finally moved, deputies were able to assess Olivia, who was cold and stiff to the touch. Believing Olivia was alive, a GCSO deputy urgently [lifted her from the clutter and rushed her outside to initiate CPR](#).

Lifesaving measures were unsuccessful, and Olivia was pronounced deceased on scene by EMS. The [OMI determined](#) that Olivia died from carbon monoxide toxicity. Darcy initially denied drug use but later admitted to smoking methamphetamine within the previous two days.

Deputies described the home to be in “complete disarray.” A sheriff’s deputy detailed horrible living conditions:

While in the residence the smell coming from the inside of the residence was such a strong and potent smell it made me feel extremely nauseous to the point I had to put a face cover on to cover my nose from the smell. The floor of the residence could not be seen due to so much trash and dirty clothes scattered all over the floor. Deputies and the Detectives had to carefully walk in the residence and try not to step on any dog feces and dog throw up. While in the residence I observed multiple small heaters in the room and a pile of burnt wood pieces in a pan in the residence as well.

There was food scattered all over the floor and the walls of the residence. There was no running water in the house and nothing to store food in at this time. There was also no sign of any food in the house either. The only food that I observed was old pizza boxes and old fast food wrappers that had old food that appeared days old. While in the residence I did not observe any source of potable water to be drank at this time.

Olivia’s death was not the result of an isolated incident, but the culmination of a long-documented pattern of abuse and neglect. CYFD had received five prior reports of abuse and neglect by Darcy and Marvin.

Over two years earlier, on February 18, 2022, Silver City Police found five-year-old Evan alone in the bed of a pickup truck, enclosed by a camper shell, in a Walmart parking lot. Evan told police that he did not know where his parents went. Darcy acknowledged that she should not have left Evan by himself. [Officers reported the incident to CYFD](#), and an investigation for lack of supervision was initiated.

During its investigation, CYFD was repeatedly made aware that Darcy and Marvin were living in conditions unfit for habitation. A former landlord described Marvin as “quick to anger” and recalled the family’s hazardous living environment. Similarly, a manager at a Quality Inn where the couple temporarily stayed noted that trash in their room was “ankle high” and often observed Marvin directing his anger toward the children. Despite these warnings, CYFD’s inquiry was limited. Five days after the referral, CYFD finally located the family outside an RV. Although the investigator briefly observed Evan and Olivia outside, the

investigator did not inspect the living quarters inside the RV. During a follow-up visit on March 8, 2022, the investigator again failed to inspect the family's living quarters.

Even this shallow investigation revealed multiple indicators of chronic neglect and instability within Marvin and Darcy's household. Marvin acknowledged that he and Darcy struggled to meet their children's basic needs, and he requested assistance with identifying food banks and other resources. The investigator also documented signs of potential educational and medical neglect. After contacting four elementary schools in Silver City, none confirmed that Evan was enrolled. Darcy's mother disclosed that Evan was unvaccinated, potentially preventing his enrollment in school. Additional concerns emerged when Darcy admitted to a history of drug use, and Marvin disclosed his own childhood experiences of abuse and neglect.

CYFD ultimately substantiated the referral on March 28, 2022, finding that Darcy failed to properly supervise Evan. The uninhabitable conditions, drug use, and neglect of the children's basic needs signaled the start of a troubling pattern that would resurface in future reports to CYFD. Despite these clear indicators of risk, CYFD failed to take any meaningful action at this early stage.

On [August 22, 2023](#), CYFD received a report after Silver City Police stopped Darcy's vehicle and found her children without car seats or seatbelts. Officers noted the vehicle had a foul odor and the children appeared extremely dirty, likely due to a lack of routine bathing or grooming. Darcy acknowledged that she struggled to maintain running water and heat in the home.

The day after that report was made, a CYFD investigator met with Darcy. Darcy claimed the family was temporarily staying with her mother while resolving water and propane issues at their residence. CYFD's safety and risk assessments—which were uninformed by even a single home visit—found that Darcy and Marvin were meeting their children's basic needs for food, clothing, shelter, and medical care. The investigator also concluded that the family's physical living conditions did not pose any immediate threats to the children's health or safety, despite the possibility that Darcy and Marvin may imminently return to their home. Surprisingly, the risk assessment indicated that neither Darcy nor Marvin had a past or current alcohol or drug problem, and that neither parent had a history of abuse or neglect as a child, contrary to the facts conveyed to CYFD by Darcy and Marvin themselves. In January 2024, the report was officially unsubstantiated, well past CYFD's 45-day investigation deadline.

On [November 27, 2023](#), and [December 8, 2023](#), CYFD received two additional reports of neglect by Darcy and Marvin, which were merged into a single investigation. The initial referral contained the following information:

- The family lacked a septic tank or toilet on their property, and the family resorted to using the restroom outdoors;
- There was no running water in the home, and the family only sporadically filled a water tank for drinking and bathing;
- Marvin was verbally abusive and prone to damaging things when angry. In one incident, Marvin broke windows in the family home and left the glass on the floor while the children walked barefoot; and
- Evan frequently missed school due to unreliable transportation.

On November 28, 2023, CYFD interviewed Darcy and Marvin, who denied lacking a toilet or water and stated their home’s electricity came from a generator. For the third straight investigation, CYFD did not complete a home visit to corroborate their assertions. Interviews with the children and school staff revealed additional issues—the children said they slept on a couch after their father broke their bed in anger, and school officials reported frequent hygiene problems. School officials also voiced concerns about possible domestic abuse in the home after seeing visible bruising on Darcy.

The second referral included in CYFD’s consolidated investigation described Evan arriving at school with “one of the worst black eyes they have seen on a child.” The reporter also pointed out that Evan had never attended school “clean.”

On December 9, 2023—21 months after the first report of neglect to CYFD—an investigator finally entered the family’s home. The CYFD investigator observed significant trash on the property, which Marvin blamed on visitors. CYFD confirmed access to running water and electricity but did not note whether the water and power came from city utilities or temporary sources such as a water tank and generator, which require frequent refilling and refueling.

That same day, CYFD unsubstantiated and closed the consolidated investigations. This hasty closure was deficient in several respects. CYFD failed to treat the reports independently, and after the December 9, 2023 home visit, no additional safety or risk assessments were completed, nor were previous assessments revised. CYFD’s investigator did not conduct a required “3+ staffing” with their supervisor, which may have produced additional investigative avenues or service referrals. Further, CYFD did not investigate the allegations of domestic abuse between Darcy and Marvin and its impact on the children, nor did the Department confirm or dispel the claims of Evan’s black eye or educational neglect.

On [January 17, 2024](#), less than two months before Olivia's death, a school official reported new allegations of domestic abuse in the household to CYFD. The reporter raised multiple concerns to CYFD, including:

- Darcy appearing at Olivia's school with a black eye and gash on her forehead, as well as broken vehicle windows, that she attributed to her husband;
- Recurring anger issues and property damage by Marvin;
- Ongoing drug use by both parents; and
- The family's effective homelessness, with no running water and dangerous living conditions.

The allegations should have sounded familiar to CYFD, as the same investigator who closed the two recent referrals was assigned to this case as well. When CYFD met with Olivia, she appeared unkempt and wore dirty clothes. She disclosed witnessing domestic violence in the home, being disciplined by getting hit on her butt, and that the children used the restroom outdoors because their toilet was full.

According to CYFD's [investigation summary](#), it made no attempts to contact Darcy or Marvin for over a month. When phone calls were finally made, they went unanswered. More than a month after the initial report, CYFD's investigator attempted to contact the family at their residence. She noted a large amount of trash on the property and three dogs running loose. When neither Darcy nor Marvin answered, the investigator left the property. The case was closed as unsubstantiated three days later—without a home inspection, parental interviews, or any assessment of the children's well-being. Two weeks later, Olivia was found dead beneath her parents, surrounded by trash, in a home heated with coal burned in a bathtub.

Each time CYFD interacted with Darcy and Marvin's family, investigators encountered a clear pattern of serious abuse and neglect. These warnings were consistently met with inaction. Had CYFD properly identified the recurring challenges, the Department could have engaged the family with more meaningful support or removed Olivia and Evan if the dangerous circumstances were not mitigated. For over two years, CYFD had been aware of the family's hazardous living conditions, as repeatedly reported by landlords, school officials, and others. The home was consistently riddled with trash; lacked reliable access to running water, heat, and electricity; and had no working toilet. Reports also described the children as consistently unwashed and wearing dirty clothes. One account even noted that the children bathed at a pet store. Despite ongoing concerns and prior admissions of drug use, there is no indication that either parent submitted to drug testing, or that CYFD evaluated how substance use might impair their ability to provide a safe and healthy environment for their kids. CYFD routinely mishandled or ignored safety and risk

assessments, and the required supervisory oversight was absent. Olivia’s death was avoidable.

b. Case Study: “Timothy W.” – Luna County

On October 23, 2024, NMSP in Luna County found eight children—as young as six months and as old as sixteen years—living in “underground mud caves” on a 35-acre property described as a trash landfill. These caves were connected by a network of tunnels, one of which led to a mattress where children slept. There were buckets containing human and rodent feces, spoiled food, construction materials, animal skeletons, broken-down vehicles, and extensive trash. The single source of power on the property was an unsecured and exposed extension cord.





Figure 15. NMSP lapel video still frames from October 23, 2024. Originally released in Faith Egbuonu, *6 Foot Deep Mud Caves': Police Body Cam Footage of Child Abuse Investigation Involving New Mexico Couple*, KOAT (May 7, 2025). From top to bottom: Property with extensive trash; and mud caves and tunnels where multiple children lived.

NMSP became aware of the situation after a 16-year-old female child attending the New Mexico National Guard Youth Challenge Program disclosed that her parents—Timothy and Viola W.—were subjecting her and her siblings to multiple acts of sexual and physical abuse. CYFD was called to investigate the abuse and became aware of the following:

- Following a prior CYFD investigation into bite marks on the 16-year-old's body, Timothy became angry and sexually assaulted her;
- On two separate occasions—at age 13 and age 16—she had been impregnated after sexual abuse. She indicated multiple unwanted sexual partners, including her father;
- Both of her pregnancies were “taken from her,” or involuntarily terminated, through barbaric means; and
- She and her siblings—including a six-month-old infant who was still breastfeeding—were often starved as a form of punishment.

According to an [Affidavit for Arrest Warrant](#) from February 2025, both parents have been criminally charged for multiple offenses, including criminal sexual penetration of a minor, child abuse, aggravated battery, and tampering with evidence.

Between 2014 and 2020, CYFD received seven referrals alleging abuse and neglect of these children. Those reports were for: (1) inadequate food, (2) inadequate clothing, (3) lack

of supervision, (4) lack of food and shelter, (5) excessive discipline, (6) physical abuse including bite and burn marks, and (7) sexual and physical abuse. CYFD deemed all seven reports unsubstantiated. The crimes against these children and the horrific conditions uncovered by NMSP were not only foreseeable—they were the very outcomes CYFD had been explicitly warned about in seven separate reports, each detailing the specific forms of abuse and neglect that ultimately came to pass.

CYFD’s indifference extended beyond its own “investigations.” According to an NMSP officer, the CYFD supervisor responsible for overseeing the seven prior investigations refused to provide NMSP the full investigative case files from CYFD, despite being legally obligated to do so. What little information the officer did receive was alarming: a CYFD attorney disclosed that their investigator failed to include critical evidence in the file, including photographs of the property—which were taken on their work phone and later deleted—along with poems written by the 16-year-old victim.

Had CYFD acted on any of the seven clear and repeated warnings, the lifelong trauma to these children and horrific living conditions uncovered during the investigation could have been minimized or prevented.

c. Case Study: “Ramon C.” – Curry County

On July 20, 2025, Clovis Police Department (CPD) officers responded to a residence where they found five-month-old Nicholas C. unresponsive, cold to the touch, and with blood on his face. Despite CPR attempts by officers and EMTs, the child was pronounced deceased at the scene. According to an arrest warrant affidavit, the child’s father Ramon C. and his friend told CPD they had placed Nicholas in a bouncer that they later found overturned, with a blanket covering Nicholas and his face pressed into the mattress. The Office of the Medical Investigator later told CPD that the child was already in full rigor mortis upon arrival at the hospital, and that the condition had begun to subside—indicating that Nicholas had died much earlier than Ramon claimed.

When confronted with OMI’s findings, Ramon’s friend changed her statement. She told investigators that she witnessed Ramon wrap Nicholas tightly in a blanket, place both hands around Nicholas’ neck, and lift him into the air. Ramon also acknowledged that he placed Nicholas in the bouncer to sleep because his crib was infested with cockroaches. During a walkthrough of the home, officers found 22-month-old infant, Leah C., sitting in a soiled diaper on a bare mattress. Officers described the home as “completely unsanitary”

and found drug paraphernalia. A search warrant revealed additional disturbing conditions in the home:

A search warrant was generated on the residence in reference to this investigation. I was informed by Lieutenant [REDACTED] of the home's conditions. I was informed that the mattress [REDACTED] was left on was dirty, and the bedroom had feces on and around the floor. The baby bottle that was located had a cockroach inside of it, and the bedroom did not appear to be appropriate for the infant to be living in. I was also informed that the bedroom that [REDACTED] was residing in was in the same filthy conditions and not suitable for a child to be staying in. I was informed there was no food for the children, and the food that was located inside the fridge was rotten and molded. There was dog feces located all throughout the home. I was told [REDACTED] had a severe diaper rash that had gone untreated, and upon officer's arrival, [REDACTED] was locked in the bedroom alone with a soiled diaper and it is unknown when she last bathed or had on a clean diaper.

Ramon C. was charged with first-degree felony child abuse resulting in Nicholas' death.

Prior to Nicholas' death, both of his parents exhibited serious risk factors that compromised their ability to safely care for him. Nicholas' mother, Wendy, had been diagnosed with bipolar disorder and had a history of psychiatric hospitalizations. In fact, Nicholas' half-sister had previously spent time in CYFD custody due to concerns about Wendy's ability to provide a stable home. During her pregnancy with Nicholas, Wendy expressed suicidal thoughts and documented her emotional distress in personal journal entries. Just one month before Nicholas died, his father Ramon filed for sole custody, alleging that Wendy was abusive and unfit to parent because of her mental health history and prior suicide attempts:

CUSTODY OPTIONS (Check one #10)

☐ 10. The parties should be awarded joint legal custody of the minor child(ren), with primary physical custody in and periods of care and responsibility consistent with the best interests of the child(ren).

☒ 10. [REDACTED] should be awarded sole legal and physical custody of the child(ren) subject to the other parent's reasonable rights of visitation. Sole legal and physical custody is in the best interest of the minor child(ren) because:

*matters of abuse, the mother has attempted suicide multiple times
I don't feel she can confidently take care of the children like they need
to be taken care of.
She is currently hospitalized for a suicide attempt*

Ramon had a documented history of violent behavior. Multiple domestic violence incidents at his home required law enforcement intervention, which posed significant risks to his children's safety. The NMDNJ viewed several videos posted by Wendy to social media, in which Ramon is seen choking her while pregnant with Nicholas. Ramon is heard screaming racial slurs and other abusive language in the presence of their young daughter Leah.

CYFD had prior knowledge that Nicholas’ caregivers were struggling to meet his basic needs. According to relatives that spoke with the NMDNJ, prior reports had been made to CYFD regarding unsafe conditions in the home. Those family members expressed disbelief at the Department’s lack of intervention, noting that the home was frequently in disarray. A few months before Nicholas’ death, CYFD visited the home following a referral from a pediatrician who was concerned that Nicholas—who was born premature and struggling with feeding—had missed a critical medical appointment. Despite this information, relatives believed CYFD failed to take any meaningful follow-up action. Each time CYFD was alerted to concerns about the family’s home environment and did nothing, it missed an opportunity to potentially alter the course of events that led to Nicholas’ death.

Following Nicholas’ death, CYFD also failed to maintain the most appropriate placement for his sister, Leah. Relatives initially took custody of Leah and expressed a clear willingness to care for her in a long-term capacity. Despite those assurances, CYFD removed Leah and placed her in a residential childcare facility in another city without explanation. This decision contradicted CYFD’s policy favoring relative placements.¹⁹⁹ Specifically, Leah’s PPW had previously assured the family she would assist them in securing custody, but she failed to follow up for three months and inaccurately informed the residential facility that Leah “had nobody” to take care of her. CYFD’s inaction in the face of documented threats to Nicholas—and its decision to ignore family placement options for Leah—revealed serious lapses in both practical judgment and basic compliance with its own policies.

d. Case Study: “Jack H. Sr.” – San Juan County

The case of Jack H. Sr. and his 11-month-old son Jack H. Jr. is the most recent example of inexcusable CYFD inaction. On February 8, 2026, San Juan County Sheriff’s Office (SJCSO) deputies responded to a call from Jack Jr.’s mother, reporting that the infant had not been seen for over a day and was last in the care of Jack Sr. According to a sworn Arrest Warrant Affidavit, SJCSO deputies searched the area around Jack Sr.’s last known location and discovered an abandoned stroller and clothing belonging to Jack Jr. The following day, deputies located Jack Jr.’s body along a ditch bank—partially buried in dirt, with his torso and legs exposed.

¹⁹⁹ CYFD Invest. Pro. PR 16, § 11.1 (“Identification and Notification of Relatives at Time of Removal”). PSD operates under the premise that placement with relatives upon removal reduces the trauma of a child’s separation from their parents and is therefore in their best interest.

Jack Sr. admitted to a SJCSO detective that he knew Jack Jr. was deceased, stating “I made a terrible mistake.” SJCSO’s investigation revealed Jack Sr.’s step-daughter was present to witness the crime. An autopsy confirmed the death was a homicide caused by blunt force trauma. The OMI pathologist conveyed Jack’s injuries and condition to the detective:

Detective J. Castillo attended the autopsy of [REDACTED] in Albuquerque, NM on 2/10/2026. Detective Castillo advised that after speaking with the doctor, he advised that [REDACTED] sustained a skull fracture and that there was dirt in his airway. An abrasion/wound was located on [REDACTED]’s forehead that was determined to be antemortem (before death) which led the doctor to believe that [REDACTED] may have been alive when his head was buried in the dirt.

Jack Sr. had a long history of violent behavior. In September 2024 SJCSO deputies responded to two separate disturbances between Jack Sr. and his fiancée. In the first, Jack Sr. struck his fiancée’s son in the face with a closed fist when the youth attempted to break up a fight between his mother and Jack Sr. In the second incident, Jack Sr. was arrested for restraining his fiancée without consent, and it was alleged that he threw objects inside the home in front of his young children. Deputies also seized a methamphetamine pipe from his possession.

On October 15 and 17, 2024, law enforcement responded to two more domestic violence incidents involving Jack Sr., both occurring in the presence of young children. During the October 17, 2024 incident, a seven-year-old reported observing Jack Sr. choking his mother, leading to aggravated battery charges and a domestic violence restraining order. Just one week before the homicide, on January 31, 2026, Jack Sr. was charged in connection with a vehicle crash while allegedly under the influence of methamphetamine.

According to public reporting, CYFD had six prior investigations involving Jack Sr. between 2023 and 2026. These investigations focused on allegations of abuse, physical neglect, medical neglect, and inadequate shelter. CYFD substantiated three of the allegations, and one investigation was pending at the time of Jack Jr.’s death. CYFD reported that the parents refused services.

Even with a pending abuse or neglect investigation and a history of three substantiated findings, CYFD continued to leave Jack Jr. in his father’s care. This case mirrors many others reviewed by the NMDOJ, where parental services are treated as merely a box to check—the services are offered, and if refused, forgotten without further action. Caregivers have little incentive to embrace real change if declining services comes without any repercussions. This case exposes a critical and recurring flaw in CYFD’s practice—repeatedly relying on voluntary compliance with services without any prospect of additional intervention places children in predictable and avoidable jeopardy.

These case studies reveal a dangerous trend in CYFD’s approach to child protection: CYFD either fails to remove children from clearly unsafe environments or reunifies them with caregivers before underlying causes of abuse and neglect have been addressed. CYFD’s flawed decisions have had devastating—and often fatal—consequences. These cases are not isolated lapses in judgment by CYFD; they demonstrate systemic breakdowns and a disregard of CYFD’s core obligations.

Reunification is not inherently virtuous if it places children back in harm’s way. It must be earned through demonstrated change, not assumed as a default outcome. Children are not test subjects for parental rehabilitation—they are human beings who deserve stability, care, and safety.

To that end, CYFD must refocus its priorities and operations on its statutory duty to protect children. This requires conducting accurate assessments, facilitating appropriate resources, and ensuring that caregivers are fully prepared to offer safe, nurturing, and supportive homes. Until that shift occurs, the cycle of abuse, neglect, trauma, and fatalities will continue.

C. Systemic Failure: Gaps in Protecting Drug-Exposed Infants

Substance abuse by adult caregivers is one of the leading causes of child abuse and neglect in New Mexico. Risks of maltreatment increase when substance use occurs during pregnancy, as prenatal drug exposure can cause serious medical complications and long-term developmental harm. From 2020 to 2023, New Mexico had an average of 1,266 newborns exposed to illegal drugs each year.²⁰⁰ Data from the U.S. Department of Health and Human Services shows that 1-in-4 childhood maltreatment victims in New Mexico had a caregiver abusing drugs.²⁰¹ Since 2009, New Mexico

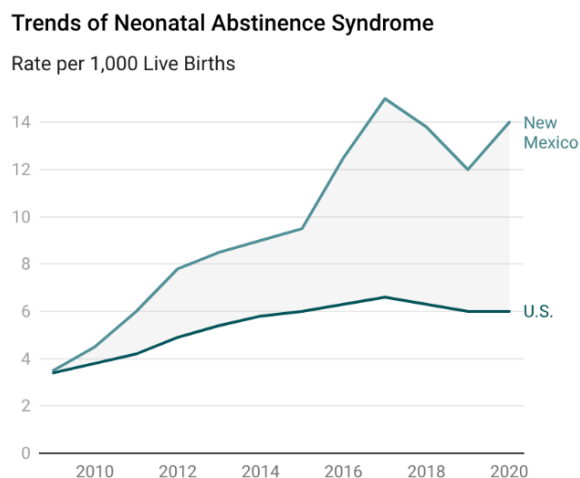


Figure 16. Rates of NAS in New Mexico compared to nationwide, 2009-2020. Reproduced from LFC CARA Program Evaluation (October 27, 2023).

²⁰⁰ Legislative Finance Committee, [Program Evaluation: Implementation and Outcomes of the Comprehensive Addiction and Recovery Act: Report #23-05](#) 9 (Oct. 27, 2023) (hereinafter “LFC CARA Program Evaluation”).

²⁰¹ LFC CARA Program Evaluation at 5.

ranks among the highest in the nation for children born with neonatal abstinence syndrome (NAS).²⁰²

The NMDOJ conducted multiple interviews with medical professionals experienced in caring for substance-exposed children in New Mexico. J.C., a former Neonatal Intensive Care Unit (NICU) nurse at Lovelace Women’s Hospital, underscored the severity of the state’s growing epidemic of newborns prenatally exposed to harmful substances. J.C. told the NMDOJ:

“When I first started in the NICU seventeen years ago, on average there would be about one baby that was withdrawing from drugs and all of the nurses would help take care of that baby because they’re constantly crying, they have diaper rashes they take a lot of care. Towards the end of my career, every nurse had a drug exposed baby and there was probably 8 to 10 nurses on a shift at a time. So within 17 years that’s how bad it’s gotten.”

1. CYFD supported legislation removing mandatory SCI reports for drug-exposed infants but failed to issue timely rules or provider training to effectively implement it.

During the 2019 legislative session, CYFD supported House Bill 230, which proposed changes to the state’s child abuse reporting statute. The bill provided that a pregnant woman’s drug use alone does not, by itself, trigger a mandatory report of child abuse or neglect to CYFD. The legislation required medical providers to create written plans of safe care (“plans of care” or “CARA plans”) to connect substance-exposed newborns and their caregivers with appropriate services, aligning New Mexico with federal requirements under the Comprehensive Addiction and Recovery Act (CARA).²⁰³ Governor Michelle Lujan Grisham signed House Bill 230 into law (New Mexico’s CARA law).²⁰⁴ As highlighted in the LFC’s CARA Program Evaluation, New Mexico’s CARA law prioritizes a public health approach over a child protection model, focusing on the treatment needs of both the newborn and their caregivers to ensure a child’s safety. New Mexico’s CARA law marked a fundamental shift in how the state addresses prenatal substance exposure:²⁰⁵

²⁰² NAS is a group of conditions caused by a baby’s withdrawal from opioids or other harmful substances they were exposed to in the womb. LFC CARA Program Evaluation at 4.

²⁰³ Comprehensive Addiction and Recovery Act, Pub. L. No. 114–198, 130 Stat. 695 (codified as amended in scattered sections of 21 and 42 U.S.C.). CARA amends the Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101, and requires states to annually report the number of substances-exposed infants, number of plans of care developed, and number of service referrals made. LFC CARA Program Evaluation at 7.

²⁰⁴ NMSA 1978, §§ 32A-3A-13 to -14, 32A-4-3.

²⁰⁵ LFC CARA Program Evaluation at 3.

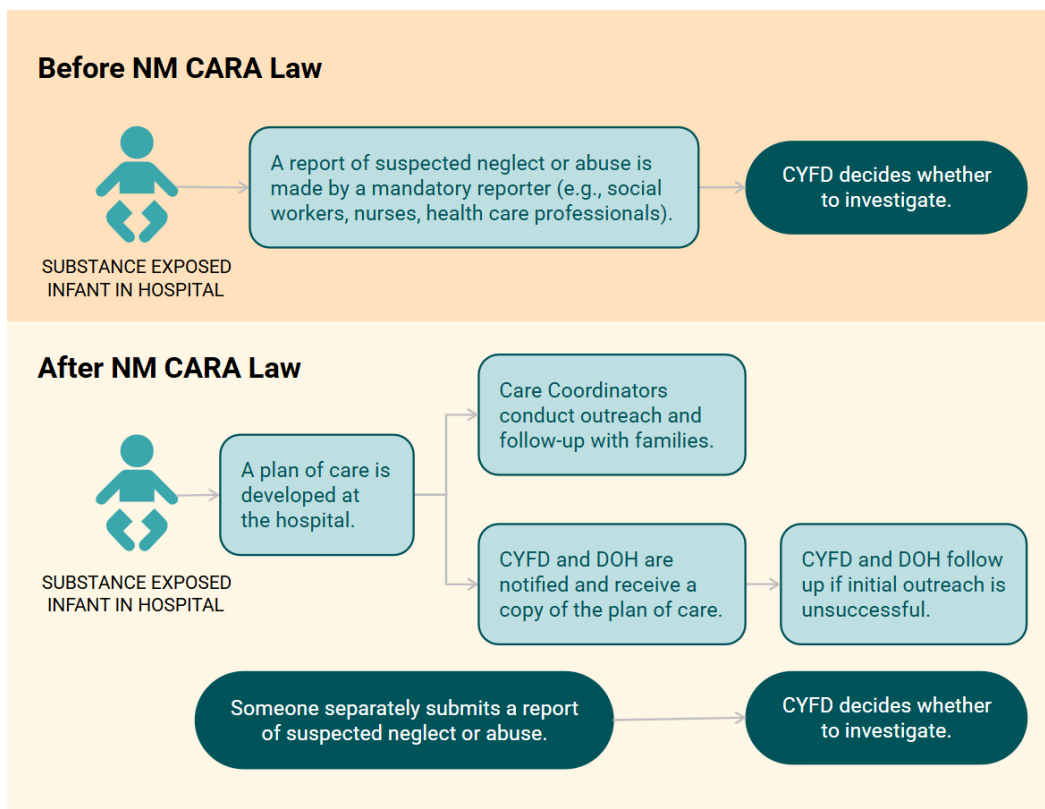


Figure 17. Framework for addressing prenatally substance-exposed newborns before and after New Mexico's CARA law. Reproduced from LFC CARA Program Evaluation (October 27, 2023).

Healthcare providers expressed confusion with these changes, and CYFD provided little to no information on when and how to report substance-exposed infants. While New Mexico's CARA law instructed providers to develop plans of care to connect families to services instead of only reporting them for abuse or neglect, CYFD offered no guidance on how such plans would be enforced. Medical professionals told the NMDOJ that they lacked clear direction from CYFD on how to proceed when a family declined or disengaged from recommended services under the plan of care.

By January 1, 2020, CYFD was statutorily obligated to develop rules to guide hospitals, birthing centers, and medical providers in the application of the new CARA law. The NMDOJ spoke with a NICU nurse who served on an advisory committee formed by CYFD to assist with creating these rules. The nurse recalled that CYFD delayed convening the group and finalized its CARA regulations without the committee's input. CYFD missed its statutory deadline by over two years, ultimately disseminating CARA regulations on February 22, 2022.²⁰⁶

²⁰⁶ LFC CARA Program Evaluation at 7.

CYFD was also required to consult with the New Mexico Department of Health to distribute training materials to hospital discharge planners and social workers. These materials were intended to assist medical providers in assessing when prenatal drug exposure should be reported as abuse or neglect to CYFD, and outlining how to create and deploy CARA plans.²⁰⁷ To the extent that any training materials were disseminated at all, they were ineffective at clarifying responsibilities of the healthcare workers. [NICU nurse J.C. described](#) the confusion staff faced when drug-exposed newborns were scheduled to be discharged:

“None of the nurses know about CARA. None of the nurses in the NICU were ever trained about CARA. . . . We had one baby that came back with a fentanyl overdose and the whole staff was completely pissed that that baby had gone home and not gotten the resources. And so we were demanding some education about what we could do.”

Hospital staff were not alone in struggling to understanding New Mexico’s CARA law. CYFD also failed to adequately train its own frontline caseworkers on CARA. Another experienced [NICU nurse, R.J., explained](#) to the NMDOH that CYFD employees often lacked even basic knowledge of the CARA law and its requirements.

2. Fragmented oversight and voluntary parental participation weaken CARA’s impact on at-risk caregivers and drug-exposed newborns.

Services offered to a family with a plan of care can include: (1) substance abuse treatment and recovery support, (2) housing assistance, (3) home visiting, (4) infant mental health for healthy social-emotional development, and (5) parenting groups. CARA Navigators²⁰⁸ employed by CYFD and DOH, along with care coordinators from private insurance companies, are primarily responsible for following up with families to ensure they engage in services under the plan of care. Since the law’s passage, numerous flaws have become increasingly evident. For instance, hospital staff explained that many CARA service providers cannot access plans of care²⁰⁹ through the current database. This limits coordination, as providers outside the hospital’s network—such as speech therapists and early intervention specialists—are unable to update the plan of care.²¹⁰

²⁰⁷ NMSA 1978, § 32A-3A-13(G).

²⁰⁸ CARA Navigators at CYFD and DOH: (1) assure compliance with state law; (2) receive plans of care and notifications of substance exposed infants; and (3) provide technical assistance and navigation to the entities and individuals involved in plans of care. 8.10.5.7(G) NMAC. As of January 2025, all CARA Navigators are now employed by the DOH. See CYFD, [Families First Strategic Plan](#) 13 (Aug. 1, 2025).

²⁰⁹ CARA plans have undergone minor revisions since 2019. A blank copy of the CARA plan is available [here](#).

²¹⁰ LFC CARA Program Evaluation at 25.

The LFC's CARA Program Evaluation noted challenges with insurance companies managing care for substance-exposed newborns. Medicaid members under Centennial Care 2.0 were assigned the lowest priority for care coordination, leading to families missing out on comprehensive assessments and services recommended for families with CARA plans.²¹¹ [NICU nurse J.C. confirmed that CARA has not functioned in practice as it was designed to.](#)

CARA plans are unenforceable. They are completely voluntary, and families can simply decline services in their entirety. The LFC's Program Evaluation highlighted troubling statistics regarding CARA's effectiveness:

- Nearly half of families with a CARA plan were not referred to any type of substance use treatment by hospital staff.²¹²
- 19% of CARA families are referred to substance use treatment but declined services.²¹³
- Only 15% of CARA families accepted referrals to some kind of substance use treatment.²¹⁴
- Nearly half of families were referred to early intervention services, but only 59% of those families ultimately participated in services.²¹⁵
- 42% of families that responded to a DOH survey 11 months after receiving a CARA plan did not know what a CARA plan was.²¹⁶

CARA Plan Referrals for Substance Abuse Treatment

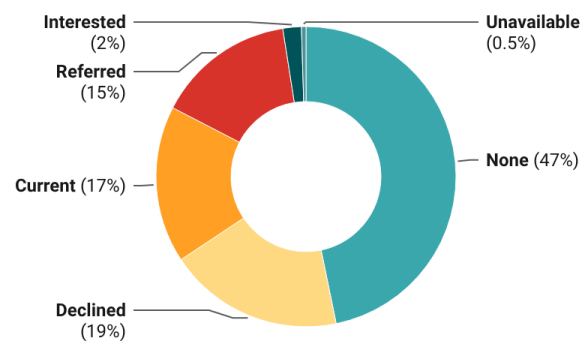


Figure 18. CARA plan referrals for substance use treatment, 2020-2021. Reproduced from LFC CARA Program Evaluation (October 27, 2023).

Despite well-documented shortcomings, CYFD frequently treats the mere existence of a CARA plan as sufficient grounds to release substance-exposed newborns from their hospital stay—frequently over the objections of medical professionals. This practice has repeatedly exposed fragile infants to preventable harm. For example, NICU nurse J.C. discussed an

²¹¹ Id.

²¹² LFC CARA Program Evaluation at 14.

²¹³ Id. at 15. The consequences of this policy were highlighted earlier in this report with Gloria F. who gave birth to a drug exposed baby on October 21, 2021. Her plan of care shows that she was offered substance abuse treatment and declined.

²¹⁴ Id.

²¹⁵ Id. at 16. Early intervention services include speech, occupational, and other therapies for newborns whose drug exposure has caused developmental delays.

²¹⁶ Id. at 25.

incident where CYFD deemed a drug-exposed newborn safe with his parents, despite concerns from medical providers, simply because a CARA plan was in place. The child died in the custody of their parents several days later. [J.C. recalled](#):

“When we called CYFD . . . and they told us on the phone, there’s a CARA plan in place, this baby is safe to go home. Then we discharged the baby on a Thursday and that baby came back on a Sunday. And he passed away, he died . . . The mom had no safety plan in place; she had a CARA plan in place. It wasn’t activated and wasn’t going to be activated until that Monday, because she went home on a Thursday. So Friday, Saturday she was by herself, Sunday she was by herself. No support, no systems, nothing . . . I admitted the baby when he came back and that’s where I got involved is like what happened to this? I still have PTSD from it. The look on his face when he came back through that unit was like pure panic on that baby’s face. And the mom was like, I couldn’t get him to stop crying. So I dipped the pacifier in fentanyl and gave it to him.”

Another former NICU nurse, A.T., described seeing the same babies return to the NICU after being discharged to drug-addicted parents with CARA plans. [Several of those newborns required emergency care due to fentanyl re-exposure](#), including one case where the parents were suspected of intentionally dosing the baby to keep them quiet.

When a plan of care is in place, CYFD routinely screens out any abuse and neglect report without further investigation—even when clear safety risks remain. B.W., a hospital nurse manager who spoke with the NMDOJ, shared that [nurses frequently face pushback from CYFD for filing abuse or neglect reports](#)—even in cases where drug-addicted parents are actively refusing the services outlined in the plan of care.

“The struggle with the SCI reports is even if we put it in, CYFD can screen it out. So, then we will say they didn’t engage in services. We have concerns and CYFD can say it’s not, I don’t want to say important enough, but this doesn’t warrant us following up and they’ll screen out the call.”

The most recent data suggests that New Mexico “tends to provide plans of care, refer to appropriate services, and *screen in cases of substance-exposed infants referred to CYFD at less than the national rates.*”²¹⁷ Of the infants with prenatal substance exposure that were referred to CYFD, 51% were screened in to receive either an investigation or alternative response.²¹⁸

²¹⁷ Id. at 18. Emphasis added.

²¹⁸ Id.

To be sure, CYFD is not the only state agency responsible for implementing New Mexico’s CARA law and overseeing its operation. Even prior to significant legislative changes in 2025, the DOH, HCA (formerly HSD), health insurance companies, medical providers, and other stakeholders also played key roles in advancing CARA’s purpose of connecting families to services through plans of care.²¹⁹ CYFD, therefore, is not solely to blame for the CARA law’s ineffectiveness.

However, CYFD’s actions hindered the ability of other responsible parties to meet their obligations. CYFD was given primary authority to implement CARA through adopting regulations upon the law’s passage in 2019. It was also responsible for educating and training system participants—an essential foundation for the law’s success. CYFD’s failure to comprehensively or timely effectuate these early steps significantly undermined the system’s ability to function as intended. Additionally, the decision to investigate allegations of abuse and neglect continues to rest solely with CYFD. Its pattern of deferring to the existence of a CARA plan—rather than thoroughly investigating parents who are clearly placing their newborns in harm’s way—has led to serious and often devastating consequences. CYFD is responsible for these failures.

The following two recent cases in Bernalillo County, involving real families anonymized using pseudonyms, highlight CYFD’s failures in implementing and operating the state’s CARA program.

3. Case Study: Two-year-old “Anthony A.’s” overdose from methamphetamines and fentanyl highlights CYFD’s early failures to implement CARA.

On July 31, 2020, Charlotte A. gave birth to Anthony A. at UNM Hospital in Albuquerque. Anthony tested positive for methamphetamine, opiates, and methadone at birth. Hospital staff made an abuse and neglect report to CYFD after Charlotte was suspected of using drugs in the hospital bathroom shortly after Anthony’s birth.²²⁰ According to [CYFD case notes](#), Charlotte left the hospital on August 2, 2020, and did not return to check on Anthony until eleven days later. Charlotte admitted to CYFD that she used meth, marijuana, and opiates during her pregnancy. Anthony’s biological father was not present at the hospital and refused to be involved in Anthony’s life. Anthony remained in the intensive care unit showing signs of withdrawal until August 14, 2020. Despite reports of Charlotte’s drug use immediately after giving birth to Anthony, CYFD did not implement a formal safety

²¹⁹ The HCA, DOH, managed care organizations, private insurers, and the Office of Superintendent of Insurance were to *consult* with CYFD to roll out rules and regulations implementing CARA. NMSA 1978, § 32A-3A-13(A) (2019, as amended 2025).

²²⁰ NMSA 1978, § 32A-4-3(G) (“Nothing in this subsection [prohibiting abuse or neglect reports based on drug use alone] shall be construed to prevent a person from reporting to the department a reasonable suspicion that a child is abused or neglected . . . based on other criteria[.]”).

plan with the family. Instead, Charlotte simply agreed that if she began using drugs again, she would leave Anthony with her mother, Teresa B.

A UNMH social worker completed a [CARA plan](#) with Charlotte prior to Anthony's discharge. The plan noted that Charlotte and Anthony were already receiving services for medication-assisted treatment, recovery support, a safe sleep plan, substance abuse counseling, and transportation. According to [CYFD case notes](#), Charlotte declined day care assistance but agreed to receive early intervention services through Alberta House:

SERVICES OFFERED/ACCEPTED/REFUSED: Early Intervention due to being born drug exposed. In Home Services due to [REDACTED] addiction and fear of relapsing.

FCM: 08/07/2020

EI: Alberta House Referral sent 08/17/2020

Day Care: Family Declined

Mental Health: [REDACTED] receives counseling with the ASAP clinic

IHS: Referral sent 08/17/2020 Warm Handoff- During FCM on 08/07/2020

CARA PLAN: 08/14/2020

At the time Anthony and Charlotte's plan of care was created, CYFD also referred the family to their In-Home Services unit.²²¹ This unit would have provided an additional layer of support to assist the family with connecting to services outlined in their CARA plan. By the time Anthony was discharged from the hospital, the family had multiple supports in place: a CYFD investigator, an In-Home Services practitioner, a Blue Cross Blue Shield care coordinator, and a CARA Navigator—all positioned to help address Charlotte's underlying challenges and support her in building a more stable foundation for parenting Anthony.

Although Anthony's plan appeared adequately staffed on paper, inadequate coordination between CYFD and providers prevented Anthony from being connected to services under his CARA plan. CYFD staff were aware that Charlotte had not followed up on the early intervention referral, yet no action was taken. Between August 17, 2020, and August 31, 2020, the early intervention provider made four unsuccessful attempts to reach Charlotte and twice notified CYFD of the issue. Despite knowledge that Charlotte's mother, Teresa, was uncooperative and unwilling to assist, CYFD continued to direct the early intervention provider to contact her to establish services with Charlotte:

²²¹ CYFD, [Home-Based Prevention Servs. \(8.10.6 NMAC\)](#) PR 8, § 5. CYFD's In-Home Services Unit assigns practitioners to deliver home-based support and services tailored to the needs of children and their caregivers.

08/31/2020 [REDACTED] - Early Intervention

Email received from [REDACTED]

"Just wanted to update you on my attempts to contact [REDACTED] regarding [REDACTED] to schedule intake. When I received the referral on 8/17/20, at 3:21pm I attempted to call moms number and no answer, so I called grandma [REDACTED] number. No answer but she returned my call. She stated that mom was not available, and I explained my reason for calling. She was very rude and defensive and stated "I don't want to have anything to do with you guys". I immediately called [REDACTED] to let her know of grandma's refusal of EI program. Then [REDACTED] notified me that she spoke with grandma and that grandma just woke up from a nap that she would return my call the next day to schedule intake. I never heard from grandma or mom. I attempted to call moms number on 8/20/20 at 10:05 am, no answer and I left a message. No call back. After speaking with [REDACTED] on 8/26/20, she spoke with mom and gave mom my contact info and suggested that I call grandma [REDACTED] number (because moms number uses wifi only) in the mornings if I don't hear from [REDACTED]. I didn't receive a call back from mom. So, today I attempted to call mom again on grandma [REDACTED] number. After 3 rings it hung up but then [REDACTED] called me back being very rude and hostile. Asking "who's this, why are you calling me". I explained who I was and why I was calling and grandma stated "how many programs is she in"? I explained that I knew of Casa De Luz and EI and unsure of any others. I began to explain again the process of EI and what EI is about and she just hung up on me."

On September 10, 2020, CYFD closed its investigation without confirming that Charlotte had connected with the early intervention services provider. Neither the CYFD investigator nor the In-Home Services practitioner ever reached out to the Blue Cross Blue Shield care coordinator or CARA Navigator to arrange for a different provider or confirm Charlotte's participation in any services. While the In-Home Services practitioner agreed to encourage Charlotte to pursue early intervention for Anthony, CYFD records show that the family never followed through with the recommended CARA plan. These services were especially critical given Charlotte's longstanding substance use and Anthony's developmental setbacks from prenatal drug exposure.

Nearly two years later, on June 15, 2022, emergency medical services were called to Teresa's home after Anthony was found unresponsive. Upon suspecting a drug overdose, EMS workers administered Narcan to Anthony on scene. He was airlifted to UNMH for further treatment. On June 18, 2022, Anthony was pronounced deceased. In his autopsy report, [OMI](#) noted that Anthony's death was caused by toxic effects of fentanyl and methamphetamine. [Socorro police later searched](#) Teresa's home, where they found fentanyl and straws with powdered residue within close reach of where Charlotte and Anthony slept. Police interviewed Charlotte as part of their investigation, and she admitted to using two fentanyl pills on the morning Anthony was taken to the hospital.

Anthony's death represents a breakdown in the CARA system, rooted in CYFD's failure to implement required rules, training, and coordination. Had CYFD properly trained its frontline caseworkers assigned to Anthony's case, they would have coordinated with providers and not closed the investigation while Charlotte continued to decline early intervention services. Notably, following Anthony's death, CYFD revised its investigations policy to require an investigator to obtain a copy of the CARA plan and to actively work to

establish services for the family—a bare minimum requirement that should have been implemented far earlier:²²²

PLANS OF CARE FOR SUBSTANCE EXPOSED NEWBORNS: Per NMSA 32A-4-3, all substance-exposed newborns must have a plan of care created. The plan of care is a written plan created by a healthcare professional that is intended to ensure the safety and well-being of a substance-exposed newly born child by addressing the treatment needs of the child and any of the child's parents, relatives, guardians, family members, or caregivers to the extent those treatment needs are relevant to the safety of the child. It is the responsibility of the investigations worker to obtain a copy of the plan of care for any substance-exposed newborn being investigated by PSD, and to work with the child's caretakers, insurance care coordinator, and service providers to establish services for the newborn and the newborn's family. Plans of care are required for both children who are placed in PSD custody as well as children who are the subject of a PS investigation but will not be placed in PSD custody. Plans of care are included in the documentation of the investigation. [06-19-2020]

Once it became clear that Charlotte was not engaged in early intervention services, CYFD was obligated to conduct a family assessment and offer additional referrals to address underlying issues jeopardizing Anthony's safety.²²³ Despite the knowledge that Charlotte had failed to follow through on two separate occasions, CYFD closed the investigation. The Department relied on the faulty assumption that she would eventually comply at the urging of the In-Home Services worker. CYFD's handling of Anthony's case violated New Mexico's CARA law and its own policies.

[Dr. Melissa Moyer's expert opinions](#) support the NMDOJ's findings.²²⁴ Dr. Moyer noted that Charlotte had three prior substantiated referrals for drug use and had previously lost custody of another child due to drug exposure. CYFD's investigator in August 2020 did not account for this history and failed to seek required supervisory oversight²²⁵ or conduct follow-up home visits. Dr. Moyer emphasized that these investigative missteps were especially concerning given CYFD's knowledge that Teresa was uncooperative with early intervention efforts. According to Dr. Moyer, direct contact with Charlotte and Anthony could have helped CYFD connect the family to CARA services or trigger a more immediate child protection response.²²⁶

4. Case Study: CYFD's new Family Services Division fails to prevent the death of four-month-old "Trevor N."

²²² CYFD Invest. Proc. PR 17, § 6 ("Plans of Care for Substance Exposed Newborns"). While [06-19-2020] is notated at the end of the policy, this cannot be the policy's effective date because CARA regulations were not promulgated until February 2022. This version of the policy is found on CYFD's webpage under the title "Investigations policies from '02.2024 to Present.'" Prior policies reviewed by the NMDOJ do not contain this provision.

²²³ NMSA 1978, § 32A-3A-14(A).

²²⁴ Dr. Moyer CYFD Final Report at 9.

²²⁵ 8.10.3.18 NMAC; CYFD Invest. Proc. PR 18, § 5 ("Families with More Than Two Investigations).

²²⁶ Dr. Moyer CYFD Final Report at 9–10.

In FY 2025, CYFD requested over \$6 million in additional state funding to create a new Family Services Division (FSD) to address its failure to effectively implement CARA.²²⁷ As part of its request, CYFD stated that 20 staff members would be dedicated to directing families to CARA services.²²⁸ The LFC expressed concerns that CYFD’s proposal duplicated functions already handled by the In-Home Services division and other Department programs.²²⁹ In other words, CYFD asked for more money to do things it was already supposed to be doing.

While the Legislature declined to fund an FSD, it continued to support and prioritize full implementation of other evidence-based prevention programs. Notwithstanding the Legislature’s priorities, CYFD internally established the FSD, reallocating resources and personnel from its investigations and permanency units. Deputy Director of Permanency Romaine Serna recalled a “mass exodus” from the permanency division to the FSD. She explained that this reallocation had cascading negative effects on caseloads and morale for those who remained.

At an LFC hearing on December 10, 2024, Secretary Casados commended the FSD for improving the Department’s efforts to connect families with services under CARA. [Secretary Casados noted](#) that managed care organizations were engaging with and monitoring families who elected services. Secretary Casados claimed that when families disengaged from their plans of care, the FSD is notified to identify barriers, re-engage the family, and make referrals for investigation as appropriate. However, despite Secretary Casados’ claims, CYFD’s FSD failed to play any meaningful role in the tragic case of Trevor N.

Trevor N. was born to drug-addicted parents on January 29, 2025. He was prenatally exposed to amphetamines and fentanyl. A report was made to SCI after Trevor’s mother, Lindsay N., and father, Diego T., appeared to be under the influence of narcotics while at the hospital.

CYFD opened an investigation into the abuse and neglect allegations contained in the report. Clear warning signs should have been evident to CYFD’s investigator. [CYFD case notes](#) show that Lindsay admitted to a two-week methamphetamine binge late in her pregnancy. Diego falsely claimed five years of sobriety, but tested positive for

²²⁷ Legislative Finance Committee, [Appropriations Recommendations for the 2025 Fiscal Year](#) 378 (Jan. 2024). The LFC noted that this funding request came despite CYFD’s assertion during House Bill 230’s debate that CARA implementation could be fully funded through federal CAPTA money. LFC CARA Program Evaluation at 29–30.

²²⁸ LFC CARA Program Evaluation at 29.

²²⁹ LFC CARA Program Evaluation at 30.

methamphetamine, cocaine, and fentanyl on February 13, 2025. UNMH nurses reported that Diego appeared high while attempting to feed Trevor. CYFD also knew that after Lindsay left the hospital on January 30, 2025, she did not return to the hospital to see her newborn until February 9, 2025.

At the time of Trevor's birth, Lindsay and Diego shared a one-room casita on Lindsay's mother's property. CYFD conducted a home visit and determined that the residence was safe for Trevor. Trevor was discharged from UNMH on February 24, 2025, and the family received a CARA plan prior to his release. On that same date, CYFD also placed Trevor on a safety plan. It designated Lindsay's mother, Dorothy N., as the safety monitor. In the safety plan, CYFD recognized that Trevor faced danger in a household where two parents were actively addicted to drugs, including the potential for harm or death if circumstances did not improve:

What is the department and/or the family concerned will happen to the children if nothing else changes?
The department is concerned that [REDACTED] will continue to be exposed to drugs and experience neglect if nothing changes which can lead to imminent harm, danger, and even death.

As part of the [safety plan](#), Dorothy was required to visit Lindsay and Diego's casita a minimum of three times per day to check on Trevor. If it appeared that Lindsay and Diego were not complying with the safety plan, Dorothy was required to immediately notify CYFD's investigator. The safety plan would expire 21 days from its signing and was scheduled for review on March 17, 2025. At that time, the CYFD investigator would reassess the situation and decide whether Trevor could safely remain with Lindsay and Diego. Instead, CYFD never saw Trevor again after his discharge from the hospital.

On June 5, 2025, BCSO was dispatched to a call of four-month-old Trevor unresponsive at his home. Diego told deputies that he, Lindsay, and Trevor had fallen asleep in the same bed, with Trevor positioned between them. When Diego woke up, Trevor was not moving, and he called 911. Lindsay told deputies that she awoke to see Trevor under Diego's arm and not breathing. BCSO described Lindsay as "slumping over" and showing outward signs of drug use. Trevor was pronounced deceased that same day after EMS efforts failed to revive him.

Both Lindsay and Diego admitted to using fentanyl and methamphetamine the day before Trevor's death. Diego told deputies that he and Lindsay had been at the casino until 4:00 or 5:00 am before falling asleep in bed with Trevor. Diego also told deputies that he and Lindsay would use drugs in the bathroom while Trevor was home. A search of the casita revealed unlivable conditions and large quantities of methamphetamine, fentanyl, and heroin, as well as firearms.



Figure 19. Photos from BCSO investigation on June 5, 2025. Clockwise from top left: Methamphetamine for sale and scale; shotgun with ammunition; uninhabitable living conditions; and drawer with heroin-filled syringe and pipe.

Between March 18 and May 27, 2025, CYFD’s investigator made ten unsuccessful attempts to reach Lindsay and Diego to discuss the safety plan and next steps. The investigator also attempted to contact Dorothy eight times during the same period, receiving no response. Although multiple home visits were attempted, one was never completed. Each visit ended when the investigator encountered a closed gate leading to the casita behind the main house.

CYFD failed to recognize and act on clear signs that Trevor was at risk. Trevor lived with parents struggling with addiction and an unresponsive safety monitor. A CYFD supervisor waited until June 3, 2025, to request a welfare check from law enforcement. CYFD policy requires an immediate protective response when danger is present and parental capacity is insufficient to ensure safety.²³⁰ Once the safety plan expired and contact with Lindsay and Dorothy failed, CYFD personnel should have promptly taken all necessary steps to conduct a home visit themselves or contacted law enforcement for assistance. Instead, CYFD waited 78 days—until two days before Trevor’s death—to take any meaningful action.

²³⁰ CYFD Invest. Proc. PR 10, § 9.4 (“Which Cases Need a Safety Assessment”).

In addition, CYFD’s oversight of the family’s CARA plan fell significantly short of professional standards and Department policy. Records show that, contrary to policy, CYFD’s investigator never contacted the Blue Cross Blue Shield (BCBS) care coordinator assigned to monitor Lindsay and Diego’s CARA plan.²³¹ There was also no communication with the DOH CARA Navigator during Trevor’s life. Notably, despite the emphasis on the FSD’s role in CARA cases, CYFD failed to involve the division in Trevor’s life at any point. CYFD fell far short of its obligations and Secretary Casados’ public assurances.

During a discussion of Trevor’s case at an LFC hearing on June 25, 2025, [Secretary Casados acknowledged](#) that CYFD did not timely follow up on the family’s safety plan and mishandled oversight of the CARA plan. However, Secretary Casados framed Trevor’s death as a system-wide failure attributable to more than CYFD. This effort to diffuse responsibility appropriately drew criticism from the panel, with one member noting:

“There comes a point in a leader’s career where they pause, and look themselves in the mirror, instead of pointing fingers. I’ve heard you point fingers so often, but I’ve never heard you actually take accountability. And that’s maybe a growth area for you as the leader of this organization because you have children’s lives on the line.”

In addition to mismanaging Lindsay and Diego’s safety and CARA plans, CYFD overlooked other clear warning signs that should have prompted a more proactive approach at the time of Trevor’s birth. For example, through a simple records search, the CYFD investigator could have easily discovered that Lindsay’s parental rights to her other two children had been terminated. CYFD also failed to consider that Lindsay was previously criminally charged with child abandonment, when she was accused of leaving her two-year-old child with a complete stranger.

Diego was a two-time convicted felon with a long history of abuse and neglect reports. CYFD’s investigator did not interview individuals familiar with Diego’s prior cases—including CYFD PPWs who had direct knowledge of those incidents. Basic inquiries could have revealed critical information and supported more aggressive Department intervention for Trevor. CYFD was aware of the risks to Trevor from the moment he was born. CYFD’s [inadequate investigation, oversight failures, and policy violations](#) contributed to Trevor’s death.

²³¹ CYFD’s PPW was required to communicate with Lindsay’s care coordinator under CYFD’s Investigations procedures. CYFD Invest. Proc. PR 17, § 6 (“Plans of Care for Substance Exposed Newborns”).

Child protective services expert Dr. Moyer further highlighted CYFD's deficiencies in her [final report](#).²³² Dr. Moyer criticized CYFD's decision to release Trevor to Lindsay and Diego given their history of abuse and neglect. She emphasized that CYFD should have immediately contacted law enforcement for a welfare check once it became clear that Lindsay, Diego, and Dorothy were not cooperating with their CARA plan.²³³ Dr. Moyer also emphasized that CYFD's failure to engage the assigned care coordinator and CARA Navigator made a difference in Trevor's case. She noted that a proper CARA plan "requires a level of oversight and communication that this case did not have."

5. CYFD relies on unqualified and uninformed safety monitors.

Trevor's case illustrates another recurring problem: CYFD often designates safety monitors who are unfit to care for high-risk, drug-exposed newborns. [Nurse manager B.W. explained](#) that a safety monitor must be capable of meeting the newborn's special medical or feeding needs and providing the level of care and supervision expected of a parent. B.W. told the NMDNJ that in her experience, [CYFD often fails to clearly explain the responsibilities to safety monitors](#), leaving them unprepared to fulfill their roles effectively. She recalled instances where safety monitors were surprised to learn the full scope of their responsibilities after they have already agreed to such designation.

Although not explicitly defined in CYFD's investigation policies, safety monitors are intended to serve as an added layer of protection for vulnerable children. Safety monitors are responsible for making sure parents follow the safety plan, and reporting any noncompliance to CYFD. Several hospital staff told the NMDNJ they encountered cases where CYFD-designated safety monitors appeared to pose as much risk to children as the parents themselves. For example, medical providers recalled CYFD appointing friends of drug-addicted parents as safety monitors—individuals whose clear intent was to return the newborn to the parents, with no genuine commitment to following the safety plan. R.J., a nurse with experience in adult and pediatric intensive care units, recalled:

"What I experienced as a nurse with safety monitors was that [the safety monitors] were giving the baby to the parents in the parking lot. You could tell that this was an even worse plan than letting the baby go home with the parents. At least the parents have a hopefully a protectiveness about the baby. But the safety monitors were scary people. And CYFD would say, yes, let them go home with the safety monitor."

²³² Dr. Moyer's CYFD Final Report at 7.

²³³ *Id.* at 8.

R.J. recounted a case where CYFD approved a [safety monitor who refused to review the safety plan](#) at all, stating she had to be at work.

Rather than serving as a meaningful safeguard for at-risk children, safety plans are often used as a default to avoid the more difficult decision to remove a child from a dangerous environment. One of the critical flaws in this practice—exemplified by Anthony and Trevor’s cases—is the appointment of safety monitors who lack the capacity or willingness to fulfill their roles.

6. CARA changes in 2025

New Mexico’s CARA law was changed significantly during the 2025 legislative session with the passage of Senate Bill 42.²³⁴ Those changes included:

- Designating the HCA as the lead state agency for developing rules to guide hospitals and other medical providers in the care of prenatally drug-exposed newborns;
- Requiring HCA to coordinate care for newborns and families with plans of safe care (POSC);
- Requiring HCA to train hospital staff and prenatal care providers;
- Requiring POSC to include substance use treatment referrals; and
- Establishing a 24-hour deadline for care coordinators to notify CYFD if parents disengage with POSC, at which point CYFD must conduct a family assessment.²³⁵

The most notable recent shift in CYFD’s approach to CARA was unrelated to the structural changes mandated under Senate Bill 42. On July 7, 2025, the Governor issued a new directive to CYFD, instructing that, “for all screened-in investigations involving children born exposed to methamphetamines, fentanyl, polysubstance, or diagnosed with fetal alcohol syndrome, the child must be taken into custody and abuse/neglect petition must be filed prior to discharge from the hospital.”²³⁶ The memo—written by CYFD’s acting general counsel—notes that there would not be any exceptions to this requirement and provides guidance on drafting court filings.

In a July 11, 2025, interview with KOB 4, Governor Lujan Grisham voiced concerns that newborns born exposed to dangerous narcotics were being released into dangerous homes where parents were not actively pursuing recovery. Governor Lujan Grisham confirmed the effect of CYFD’s new directive:

²³⁴ S.B. 42, 57th Leg., 1st Sess. (N.M. 2025).

²³⁵ NMSA 1978, §§ 32A-3A-13(A), -14(A).

²³⁶ Esteban Candelaria and Daniel Chacon, [New Mexico Governor Plans to Crack Down on Families with Babies Born Addicted](#), Santa Fe New Mexican. (July 9, 2025).

“We’ll temporarily take custody. We’ll have it looked at by a judge every single time, but none of these children are going home until you’re in active recovery.”²³⁷

Soon after the directive was issued, concerns emerged about its feasibility and unintended consequences. Hospital leaders warned that requiring infants to remain in care while CYFD determined placement or awaited court hearings would further impact an already-strained healthcare workforce.²³⁸ Some stakeholders criticized the approach as overly punitive, arguing it lacked sufficient focus on addressing the root causes of substance use as CARA intended. Others questioned the system’s capacity to safely place a growing number of high-needs infants in an overly-stressed foster care network.

Healthcare workers confirmed to the NMDNJ that CYFD has not pursued custody and ensured judicial review of many cases involving drug-exposed infants. One [early intervention service provider described](#) a case in which law enforcement placed a drug-exposed infant on a 72-hour hold on July 12, 2025. The hold was intended to give CYFD time to file a motion for custody under its recent directive. No petition was filed. CYFD released the hold and allowed the child to be discharged under the care of the paternal grandmother.

At an LFC hearing on August 18, 2025, Secretary Casados confirmed that CYFD was only pursuing removal petitions if the Department conducted a home assessment and determined the environment would be unsafe for the child. Secretary Casados told the LFC that between July 7, 2025, and August 18, 2025, CYFD identified 57 drug-exposed infants, but only filed a petition in 29 of those cases (51%).²³⁹ By November 2025, CYFD announced that roughly 100 drug-exposed newborns had been taken into state custody under the July directive.²⁴⁰

CYFD’s own publicly-reported data indicates the Department lacks an accurate understanding of how many drug-exposed newborns have been affected by this initiative. In November 2025, a CYFD spokesperson reported that of 116 families investigated since the July directive, 90 newborns were taken into state custody.²⁴¹ This would imply that only 26 children were not taken into custody—fewer than the number (28) that Secretary Casados confirmed had not been taken into custody three months earlier. Additionally, CYFD’s

²³⁷ Emily Faith, [Changes are Coming to a Controversial Child Welfare Program](#), KOB 4 (July 11, 2025).

²³⁸ Esteban Candelaria and Daniel Chacon, [Memo Outlines New Mexico Hospitals’ Concern Over Governor’s Policy Change on Drug-Exposed Infants](#), Santa Fe New Mexican. (July 22, 2025).

²³⁹ Id.

²³⁹ House Legislative Health and Human Services Committee Hearing Transcript 16:19-17:3 (Aug. 18, 2025) (statement of Sec. Teresa Casados).

²⁴⁰ Esteban Candelaria, [Babies exposed to drugs taken into CYFD custody reaches triple digits, department says](#), Searchlight New Mexico. (November 24, 2025).

²⁴¹ Id.

reported breakdown—90 children taken into custody, 16 released to relatives, and 8 cases where the court found insufficient evidence—totals 114, which does not match the 116 investigations cited by the Department.²⁴²

Since 2019, CYFD’s implementation of New Mexico’s CARA law has been marked by inconsistent execution and fragmented coordination with partner agencies. The success of the 2025 reforms and subsequent policy directives will ultimately depend on the state’s ability to sustain a child-centered focus on the unique vulnerabilities of substance-exposed infants. The stakes are not academic or theoretical—there are over 1,000 drug-exposed infants with CARA plans in New Mexico²⁴³ whose lives depend on the system getting this right.

D. Systemic Failure: Undermining Law Enforcement

When functioning as intended, CYFD works in close partnership with law enforcement to ensure children’s safety. In fact, CYFD’s investigation policies refer to “law enforcement” over 100 times, underscoring the Department’s obligation to collaborate with public safety agencies. CYFD investigators are expected to cooperate with law enforcement in joint investigations and coordinate interviews with involved parties.²⁴⁴ CYFD investigators can request law enforcement conduct welfare checks of families,²⁴⁵ and in cases involving physical or sexual abuse, law enforcement assists CYFD with documenting injuries and arranging medical examinations.²⁴⁶ Law enforcement also has the statutory authority to take a child into temporary custody when the officer has evidence to believe that the child is abused or neglected and there is an immediate threat to the child’s safety.

The NMDOJ spoke with law enforcement personnel from multiple agencies. From field detectives to command-level leadership, their feedback about CYFD was consistent: law enforcement’s efforts to collaborate with CYFD are often met with opposition rather than cooperation. Common themes included: (1) CYFD frequently obstructs officers’ attempts to initiate 72-hour holds; (2) CYFD routinely disregards credible safety concerns to children when raised by law enforcement; and (3) CYFD’s inaction often significantly impedes criminal investigations.

²⁴² *Id.*

²⁴³ *Id.* at 4:9-10.

²⁴⁴ CYFD Invest. Proc. PR 10, § 7.1 (“Coordination with Law Enforcement”).

²⁴⁵ CYFD Invest. Proc. PR 10, § 7.3 (“Health and Safety or Welfare Check”).

²⁴⁶ CYFD Invest. Proc. PR 11, §§ 8.2, 8.3 (“Physical and Sexual Abuse Examinations”).

1. Recurring barriers to effective collaboration

Law enforcement officials identified CYFD’s resistance to 72-hour holds—even in high-risk situations—as a frequent source of tension. Officers have authority to take temporary protective custody of children they believe are at immediate risk of abuse or neglect. However, CYFD is responsible for determining whether facts support filing an abuse or neglect petition in Children’s Court to secure a longer-term placement or whether returning the child to a parent is appropriate.²⁴⁷ When a law enforcement officer initiates a 72-hour hold, CYFD completes a safety assessment, and in CYFD’s discretion, may be returned home at any time during that three-day period.²⁴⁸

Whether due to CYFD’s misuse of the safety assessment tool²⁴⁹ or its lack of available placements for longer-term custody, the result is the same—children are often returned to unsafe environments, prompting repeated intervention from law enforcement. One sergeant recalled CYFD investigators telling field officers that certain situations “[do not] qualify for a 72-hour hold,” despite there being no such categorical prohibitions. In other instances, CYFD investigators refused to provide officers with a copy of the paperwork required to initiate the hold process.²⁵⁰ The sergeant recalled cases in which CYFD returned children to a parent after doing little more than circling the block, thereby placing the children right back in the unsafe environment from where they were removed. Detectives who specialize in investigating crimes against children recounted instances in which CYFD returned children to unsafe environments during the 72-hour hold period, only for officers/deputies to be called back shortly thereafter. According to one former APD detective, “CYFD’s main mission is not the child’s safety. Their number one goal is to keep kids with family, no matter what.”

As discussed at length elsewhere in this report, CYFD routinely relies on safety plans in lieu of filing petitions for abuse and neglect within the 72-hour hold period. Law enforcement uniformly reported to the NMDNJ that safety plans are used as convenient substitutes for more robust protective measures, but often fail to ensure children remain in a safe environment. Detectives described instances in which they raised concerns about the CYFD-designated safety monitor or respite placement,²⁵¹ only for CYFD to ignore or minimize

²⁴⁷ NMSA 1978, § 32A-4-6(C).

²⁴⁸ CYFD Invest. Proc. PR 10, § 5.2 (“Accepting Custody from Law Enforcement”).

²⁴⁹ The NMDNJ’s investigation documented multiple cases in which CYFD investigators filled out safety and risk assessment tools incompletely or inaccurately, to the detriment of children.

²⁵⁰ CYFD Invest. Proc. PR 16, § 5.2 (When a law enforcement officer seeks to place a child into the Department’s custody, CYFD requests the officer fill out a “PSD statement of reasonable grounds for temporary PSD custody” form located on CYFD’s intranet).

²⁵¹ CYFD Invest. Proc. PR 10, § 10.2 (“The Role of Brief Respite in a Safety Plan”). Respite may be used, for up to five days, to assist the family during a safety plan. However, this is not a legal placement, and the safety plan includes action steps for what should occur if the offending caregiver contacts the child.

those concerns. Further, without CYFD’s willing enforcement, there is no penalty for breaching a safety plan. One detective noted that he had “never seen a situation where there [was] a violation of a safety plan and CYFD seeks a petition [to take a child into custody].”

CYFD’s opposition to 72-hour holds and overreliance on safety plans also impairs the integrity and effectiveness of law enforcement investigations. When CYFD returns children to alleged abusive or neglectful caregivers during the 72-hour hold period, those caregivers often refuse law enforcement requests for CART exams or forensic interviews. In contrast, when CYFD faithfully honors the 72-hour hold, a child remains in state custody during that time, and CYFD—acting as the child’s legal custodian—can authorize law enforcement to proceed with critical investigative steps. Law enforcement officials explained that even when offending parents appear to cooperate, their presence has a chilling effect on children’s willingness to speak openly. Detectives frequently observed that when children remained in parental custody before a forensic interview, their statements were often clearly coached. In short, when CYFD prematurely ends 72-hour holds, it undermines proper investigation and ultimately limits the State’s ability to hold abusive or neglectful parents accountable.

Across agencies, law enforcement reported other common barriers in effectively working with CYFD, including:

- Lack of communication—There are prolonged communication gaps causing officers to be unable to reach CYFD investigators and PPWs;
- Lack of investigator autonomy—CYFD investigators are not empowered to act independently, requiring several layers of supervisor input before decisions can be made;
- Unpredictable results—CYFD investigators often reach different conclusions in similar circumstances, suggesting insufficient understanding and inconsistent enforcement of policy;
- Inadequate interviews—CYFD investigators are ill-equipped to conduct developmentally appropriate or trauma-sensitive child interviews; and
- Exclusion from family-centered meetings—Blanket exclusion from FCMs leaves CYFD without critical perspectives that could strengthen child protection and family support.

The current disconnect between law enforcement and CYFD is not an inherent feature of the child welfare system. A former APD detective who served in the Crimes Against Children Unit recalled that both departments historically worked together more cohesively, even sharing an office building at one point. Over time, however, CYFD has become increasingly territorial. While one sergeant noted some recent improvements in

communication, he emphasized that these gains were largely driven by individual relationships rather than organization-wide changes.

2. Cases from the APD Crimes Against Children Unit (CACU)

The NMDOJ conducted a targeted review of APD CACU investigations to evaluate CYFD's practices and inter-departmental cooperation. [Eleven \(11\) noteworthy investigations between July 2021 and May 2025](#) illustrate many of the friction points that law enforcement officials described to the NMDOJ. A snapshot of five selected investigations follows.

a. July-October 2021 – “Gregory G.” and “Sonia A.”

Gregory and Sonia had four children together—Eddie A., twin brothers Brian A. and Justin A., and Rachel A. By the summer of 2021, CYFD had investigated the couple six times for allegations of abuse or neglect. As of July 2021, Sonia and Gregory were living separately. All the children lived with Sonia except Eddie, who lived with Gregory. On July 21, 2021, APD and CYFD responded to Sonia's apartment after neighbors reported she was mistreating the children and exposing them to extreme heat for several hours. Upon arrival, APD observed that Sonia appeared to be either under the influence of drugs or having a mental health crisis. CYFD assigned an investigator with no background in social work who had been with the Department for approximately six months.

Brian, Justin, and Rachel were removed from Sonia's custody. Law enforcement advised CYFD against placing the children with their father Gregory, citing serious concerns about his ability to care for four young children with complex needs.²⁵² Gregory had a criminal history that included charges of aggravated battery, aggravated assault against a household member, and false imprisonment. At the time of placement, Gregory had an outstanding warrant for his arrest. Despite these warnings, CYFD placed the children in Gregory's care.

After placement, CYFD quickly learned that Gregory was: (1) overwhelmed by parenting four special needs children; (2) not following through with services or programs to which the family had been referred; and (3) watching the children at home rather than enrolling them in childcare.

On October 1, 2021, less than three months after placement, then two-year-old Rachel was found deceased in Gregory's home. An [autopsy](#) revealed 10-15 bruises on Rachel's face, head, arms, and legs at various stages of healing, and multiple burns across her body. The pathologist also noted both acute and healing brain bleeds, indicating more than one episode of blunt force trauma. The cause of death was blunt head trauma, and the

²⁵² Brian had developmental and speech delays. Justin had autism and exhibited developmental delays and behavioral challenges. Rachel was minimally verbal and not toilet trained.

manner of death was ruled a homicide.²⁵³ A CART exam for Rachel's siblings found further physical abuse:

ASSESSMENT:

██████ is a 4-year-old twin male who presented to care following the death of his 2-year-old sister due to blunt force trauma, including head trauma, currently under investigation for homicide. He was seen for screening evaluation as a result. ██████ has documented developmental delays, concern for autism spectrum disorder and minimal reported history of self-harm to a much lesser degree than that reported for siblings. ██████ has injuries on physical examination newly appreciated since 7/2021 CART evaluation, including patterned injury to the left back and left thigh concerning for impact injury by solid implement. Perianal bruising represents acute injury that is not consistent with accidental injury of childhood and indicates physical abuse. Sexual abuse cannot be eliminated by medical evaluation.

b. May 2022

A mother of four children self-reported to CYFD that she had been drinking daily, failed to enroll the children in school, and attempted suicide in front of them. CYFD temporarily placed two children with their maternal grandfather and two with their biological father, despite APD warnings against these placements. APD advised CYFD that the grandfather had a history of domestic violence and child abuse reports, and would be responsible for caring for 10 children—including a newborn—if the placement were made. The children's father and mother had a combined history of 26 child protective services investigations by CYFD. APD documented their concerns in a police report:

Officer Riechers conducted a background check and located various CYFD and domestic dispute reports involving ██████ and ██████. According to previous reports, there were two incidents involving ██████ as a suspect of child abuse with video evidence. It was also a concern to officers that there are ten children that would be in the residence, including a newborn. Officer Riechers also found various CYFD and domestic dispute reports against ██████ and ██████'s father, ██████. Officers expressed these concerns with CYFD worker, ██████.

CYFD apparently did not believe these placements posed any danger to the children. When an [APD detective expressed concern](#) and stated she was “going to fight for putting the kids in the safest situation possible,” the CYFD investigator—who had only three weeks of field experience—responded, “I see your perspective, and I see kind of on the side of the Department too, where he's not on the report as a perpetrator.” This response reflected a fundamental misalignment with CYFD's child protection mission. Moreover, concluding that placement was appropriate solely because the individuals weren't named in the current abuse and neglect report reflects a troubling absence of common sense.

To avoid this high-risk placement, APD sought a hold to remove the children. CYFD's investigator informed law enforcement that she would follow up with placement details, but

²⁵³ Gregory was found guilty of second-degree murder and child abuse. He is currently serving a 28-year prison sentence.

failed to do so. The investigator would later refuse to answer multiple calls from APD. Officers later learned that CYFD failed to honor the hold and maintained the original placement.

c. November 2022

A six-week-old child was found with multiple rib fractures while in the care of his father. Subsequent CART examinations of the child's two-year-old half-sister showed similar rib fractures and a skull fracture. CYFD initially removed the children but allowed them to return home without filing a petition for custody, against advice of law enforcement. By March 2023, the two-year-old half-sister was again hospitalized with severe injuries while in the care of her father. A CART exam revealed a new skull fracture, multiple vertebrae compression fractures, and a brain bleed. The examiner noted that the child "once again presents with abusive injuries." The father ultimately pled guilty to a second-degree felony and was sentenced to prison.

d. July-August 2023

In July 2023, APD investigated a case involving an eight-year-old who disclosed to daycare staff that her father hit her and her six-year-old sibling. CYFD had received 27 prior abuse and neglect reports involving the family, including four substantiated investigations for issues such as inadequate shelter and excessive discipline. [During a walkthrough of the family home](#), APD documented holes in the drywall and doors, no air conditioning, broken glass scattered throughout, a single sparsely furnished room for three children, and feces smeared on the walls. Due to the hazardous living conditions, officers initiated a 72-hour hold to remove the children into CYFD custody.

On August 5, 2023, APD was dispatched to the same address for a child-neglect call. The habitability of the home had not changed—a strong odor of feces permeated throughout the home, it had no air conditioning, and dead bugs floated in standing water in the bathtub. When APD asked CYFD about the 72-hour hold initiated three weeks earlier, CYFD's investigator told APD that the children were never removed and CYFD "brought them back right away," apparently without requiring the family to improve living conditions. The officer noted in the report:

I asked [REDACTED] the circumstances of the children being brought back to the residence after the initial 72-hour hold. [REDACTED] advised today's visit was a follow-up from that incident. [REDACTED] explained the children were never removed previously and that CYFD had brought them back right away and created a safety plan with a family member. [REDACTED] advised CYFD never went through with the 72-hour hold because they stopped that process on their end.

e. February 2025

While in foster care, a nine-year-old disclosed prior sexual abuse by her 17-year-old sister. As the child's legal custodian, CYFD was responsible for authorizing a forensic

interview. Despite at least six outreach attempts by APD detectives to the assigned PPW, two supervisors, and the associate deputy director, CYFD did not respond. The interview was ultimately conducted after a two-month delay and two rescheduled appointments.

These case studies reflect only a fraction of the concerning incidents shared by law enforcement officials. When CYFD resists collaboration with law enforcement, investigations suffer, children face greater risk, and public trust in the systems meant to protect them is diminished.

3. Case Study: CYFD inaction leaves law enforcement to manage escalating crises in “Alexis D.’s” family.

Alexis D.’s case is characterized by repeated missed opportunities by CYFD to intervene in a chronically unstable household—despite years of warning signs—leaving law enforcement to manage escalating crises that the child welfare system failed to address.

Alexis, an Albuquerque resident, has five children from three separate fathers. To protect their identities, each member of the family is referred to by a pseudonym:

- First partner, Lawrence Sr.: One son, Lawrence Jr. (YOB: 2004);
- Ex-husband, Abraham Sr.: Three children—Karen (YOB: 2009), Abraham Jr. (YOB: 2015), and Charles (YOB: 2017). Alexis also regularly cares for her granddaughter, Sierra (YOB: 2023), who is Karen’s daughter; and
- Most recent partner, Vincent: One daughter, Cade (YOB: 2023).

Between 2007 and 2025, law enforcement responded to *176 calls for service* at Alexis’ residence. In *63 of those incidents*, CYFD was either notified or actively investigating concerns related to Alexis’ children. The reports CYFD received about Alexis’ household included: child abuse and abandonments, suicidal threats, violations of CYFD safety plans, sexual assault, aggravated batteries and assaults against household members, and repeated incidents of children running away.

In addition to child welfare concerns, APD and BCSO responded to other criminal activity involving family members. Reports concerned larceny, shoplifting, residential burglary, possession of controlled substances, restraining order violations, neighbor disputes, and battery against healthcare workers. Court records indicate that Alexis’ ex-husband, Abraham Sr., has felony convictions for shooting at or from a motor vehicle, aggravated battery, receiving or transferring a stolen motor vehicle, and possession of controlled substances. Abraham Sr. has also been arrested for domestic violence against Alexis on multiple occasions. Alexis’ boyfriend, Vincent S., also has multiple felony

convictions for aggravated assault against a household member, aggravated burglary, aggravated assault with a deadly weapon, criminal damage to property, felon in possession of a firearm, and battery upon a peace officer. Vincent has also been arrested for domestic violence, including a physical attack on Alexis while she was pregnant.

Alexis' children have lived in traumatic environments their entire lives. Alexis' daughter Karen was repeatedly exposed to physical and emotional abuse, unstable living conditions, and inadequate protection despite involvement from CYFD. From 2014 to 2022, police responded to at least 20 incidents involving Karen. After being temporarily removed from Alexis' care by CYFD on multiple occasions, Karen spent extended periods living with her great-grandparents under safety plans or other arrangements. Each time CYFD attempted trial home visits and reunification with Alexis, new incidents would occur, causing the cycle of intervention and removal to repeat. Law enforcement records demonstrate that Karen often endured distressing and harmful circumstances. Examples include:

- July 2, 2017—BCSO responded after Abraham Sr. was seen grabbing eight-year-old Karen by the neck in “a choking manner.” Karen told deputies that several days earlier her father held her down on the couch and hit her.
- [July 5, 2020](#)—After being reunified with Alexis, then 11-year-old Karen arrived at a former foster parent's home asking for a ride because Alexis was “drunk or something” and left Karen at a park. CYFD was notified.
- December 18, 2021—While living with her great-grandmother, then 12-year-old Karen drove herself to a hotel in a high-crime area and stayed there alone for 5 days. CYFD accepted the report but declined to send an investigator at that time.

Younger brothers Abraham Jr. and Charles regularly experienced police intervention as well. Between 2020 and 2025, law enforcement responded to more than 40 incidents involving Abraham Jr. and Charles, including repeated runaways, threats of self-harm or harm to others, domestic violence, and lack of supervision. Among these numerous incidents:

- [October 19, 2022](#)—An elementary school counselor reported to CYFD that then five-year-old Charles repeatedly threatened to stab himself with scissors and showed ongoing aggressive behavior. School staff noted that Alexis had not followed through with recommended behavioral support.
- [January 24, 2023](#)—Neighbors called police about a domestic violence incident between Alexis and Vincent. Alexis told deputies that Vincent punched her in the mouth during an argument, causing her to bleed. Abraham Jr. and Charles witnessed the incident. Abraham later disclosed to school officials that Vincent recently hit his mother with a shovel on her face and chest, and that he feared she

might die from blood loss. A CYFD supervisor noted severe danger to the children in this environment:

CPS Intake Report

Supervisor Narration :

P1. The information in this report meets criteria for emotional abuse due to domestic violence and other neglect/endangerment per Structured Decision Making Tool. Parent, guardian, or custodian has knowingly, intentionally, or negligently placed the child in a situation that may endanger or did endanger the child's life or health.

- November 25, 2024—School officials overheard then nine-year-old Abraham Jr. say that his mother had thrown him out of the house because she was drunk. Abraham Jr. suggested this had happened on multiple occasions. CYFD's intake report acknowledged Alexis' alcohol abuse.

By late 2024 and into 2025, Alexis repeatedly asked CYFD for more support with her family. On December 11, 2024, Alexis called in a report to CYFD, stating that she "couldn't do it anymore" and feared for her children's safety. CYFD's intake report indicated that Alexis "begged [a] SCI worker to send help immediately." A CYFD supervisor noted concerns that Alexis was unable to properly attend to the children. Again on December 14, 2024, Alexis told BCSO deputies that she "needed help with her boys" and that their behavior was affecting her mental health. A report was made to CYFD but was screened-out without further investigation. A CYFD supervisor felt that Alexis' reports were not enough to pursue further involvement.

On January 20, 2025, BCSO was dispatched to assist Alexis in locating Abraham Jr. and Charles. Alexis stated that her boys frequently ran away, and she was unable to search for them due to caring for two toddlers. Alexis also said that she was trying unsuccessfully to reach CYFD for "assistance with parenting issues." One week later, BCSO again returned to help search for Abraham Jr. and Charles. BCSO notified CYFD, stating that Alexis "advised she was not able to take care of the kids" and "appears very overwhelmed." Alexis' pleas for help should have acted as alarm bells for CYFD to take more decisive action. Instead, CYFD's lack of timely intervention allowed circumstances to escalate, ultimately resulting in two dangerous incidents involving firearms in a single week.

On February 9, 2025, Alexis returned home with nine-year-old Abraham Jr., seven-year-old Charles, and her one-year-old daughter and granddaughter. Alexis' recent ex-boyfriend Vincent, who lived in a vehicle on the property, began arguing with her. During the confrontation, Vincent pointed a firearm at Alexis and then at the two boys, stating "I'm going to hurt you." Vincent fled before deputies arrived. BCSO made a report to CYFD, and a

reviewing supervisor concluded that the parents placed the child in a situation that endangered them:

CPS Intake Report

Supervisor Narration :

P1. The information in this report meets criteria for emotional abuse due domestic violence and other neglect/endangerment per Structured Decision Making Tool. Parent, guardian, or custodian has knowingly, intentionally, or negligently placed the child in a situation that may endanger or did endanger the child's life or health.

This finding mirrored the exact wording from the CPS intake report from January 24, 2023, highlighting that CYFD had been well aware of the risks to the children's safety over two years earlier. During that time, the children were repeatedly exposed to chaos and trauma. Despite Alexis' pleas for help, and a violent ex-boyfriend on the property with access to deadly weapons, CYFD chose to not intervene. This inaction nearly cost Abraham Jr. and Charles their lives.

On February 16, 2025, [law enforcement responded](#) to a report that nine-year-old Abraham Jr. and seven-year-old Charles were in possession of a firearm. Deputies discovered the boys had accessed the same handgun that Vincent used to threaten the family one week prior. Alexis reported seeing the boys "run the slide to the firearm" before running into a nearby field. [Law enforcement drone footage](#) captured Abraham Jr. and Charles on the side of a neighbor's home, passing a firearm back and forth. The boys threatened to shoot deputies, and Charles was seen pointing the weapon with his finger on the trigger. Deputies fired two non-lethal impact rounds to startle them, and were ultimately able to disarm the children without injury. The firearm had a live round in the chamber.²⁵⁴



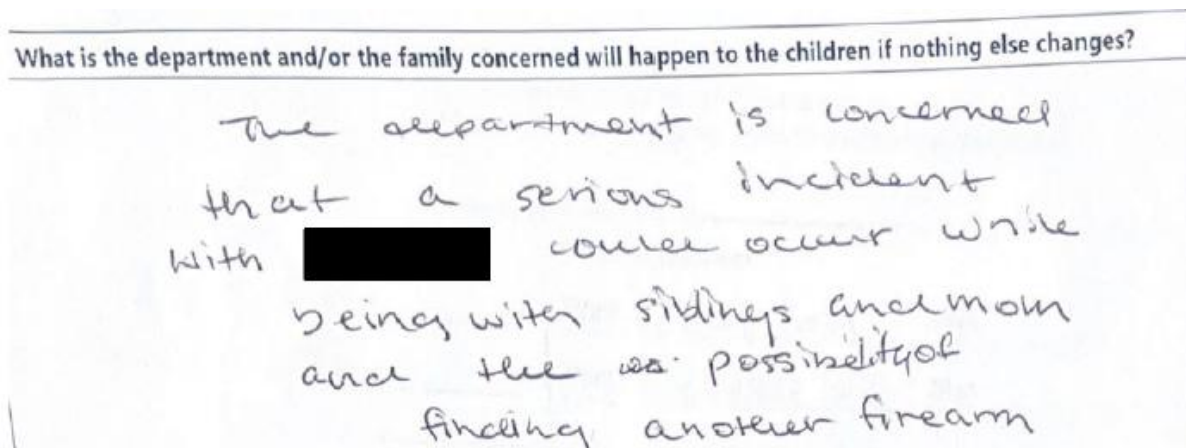
Figure 20. BCSO drone footage on February 16, 2025, showing seven-year-old Charles pointing firearm.

Incredibly, CYFD pushed back on BCSO's decision to initiate a 72-hour hold after the incident. The lead [BCSO detective's lapel video](#) recorded the disagreement, during which the CYFD investigator stated that her supervisor was "pretty against doing the hold." The detective reaffirmed his intent to proceed, citing the frequency and escalating nature of

²⁵⁴ The vehicle from which the children accessed the firearm had multiple unspent rounds.

incidents involving the family and the ongoing risk of firearm access. He told the CYFD investigator, “the kids could have died today” and “I don’t ever want this to happen again.”

BCSO’s detective spoke with the CYFD supervisor. The supervisor was skeptical that Alexis committed child abuse or neglect sufficient to take Abraham Jr. and Charles into state custody.²⁵⁵ The supervisor later acknowledged that the [number of children already at the CYFD office was a factor](#) in the decision not to take Abraham Jr. and Charles into state custody. On February 16, 2025, CYFD moved forward with a safety plan that temporarily placed the children with their paternal grandmother. In that plan, CYFD recognized the ongoing danger posed when the siblings remained in Alexis’ care:



Any stability resulting from the safety plan was short-lived. CYFD failed to offer Alexis the services or support necessary to strengthen her ability to effectively parent Abraham Jr. and Charles. In the nearly three months following this near-fatal incident, law enforcement was called out to Alexis’ residence 20 more times, with 16 dispatches requiring a formal report or notification to CYFD. Between February 16, 2025, and May 12, 2025, BCSO documented the following incidents involving Abraham Jr. and Charles:

- Charles’ refusal to attend school and eventual suspension
- Bite marks and scratches on Charles
- Theft of neighbor’s property
- Multiple instances of both boys running away, often miles from their residence
- Carrying around a toy rifle
- Possession of a firearm magazine with live rounds
- Breaking into a vacant residence and turning on a gas stove, filling the house with dangerous fumes
- Vandalizing a neighbor’s vehicle.

²⁵⁵ A neglected child is defined as one “who is without proper parental care and control . . . necessary for the child’s well-being because of faults or habits of the child’s parent.” 8.10.3.7(BB) NMAC. Alexis’ inability to prevent two elementary-aged from freely accessing deadly weapons and roaming unsupervised through a residential neighborhood falls within this definition.

Considering the mounting threats to the children and recurring access to firearm components, law enforcement made multiple attempts to have Abraham Jr. and Charles moved to a more stable environment. On March 12, 2025, after Charles refused to go to school, Alexis again expressed that she could not care for her sons. CYFD accepted a BCSO hold, but quickly released it and returned the boys to Alexis. On April 23, 2025, Abraham Jr. and Charles were left unsupervised for an extended period. They vandalized a neighbor's vehicle by drilling holes in the tires and putting dirt in the gas tank. CYFD declined a 72-hour hold and opted for another safety plan with the boys' paternal grandmother. On May 4, 2025, the grandmother told CYFD she wanted to relinquish temporary custody of Charles because she didn't "want to do anything to him that she will regret." CYFD did not consider this information to be "high risk." That same day, BCSO deputies found Abraham Jr. and Charles locked outside in the rain. Although CYFD stated their intent to conduct a welfare check, the Department never followed through.

CYFD permitted this pattern of escalating risk to continue until May 13, 2025. On that date, BCSO Special Victims Unit (SVU) began investigating an incident reported by Alexis in which Charles placed his one-year-old brother's hand over his own groin and manipulated it to look like the one-year-old was masturbating. Alexis later acknowledged that Charles would put "sweet things" on his penis and have his younger brother latch onto it. A 72-hour hold was sought and accepted by CYFD, and Charles was transported to UNMH for a psychiatric evaluation. Charles was eventually placed with a foster family while Abraham Jr. remained in Alexis' care. Had CYFD responded appropriately to the mounting pattern of child endangerment and behavioral red flags, Charles' sexualized conduct might have been prevented.

After Charles was placed with a foster family, CYFD arranged for twice-weekly visits with his mother and siblings. Serious issues continued during those visits. In June 2025, Charles and Abraham Jr. ran away during a CYFD-supervised visit and were found over an hour later at a community center. In July 2025, during another visit, the boys threatened the CYFD PPW and broke into his vehicle, refusing to come out for more than an hour.

Alexis' children were not safe in her care, and they faced a substantial risk of future abuse or neglect. Under CYFD policy, such conditions required the Department to facilitate services and resources for Alexis and her family. Based on investigation decisions, safety assessments, and risk scores, CYFD investigators should have initiated referrals to community-based programs or arranged intensive family support services through the Department.²⁵⁶ While CYFD eventually provided an In-Home Services practitioner, this

²⁵⁶ CYFD Invest. Proc. PR 10, §§ 11.5 ("Risk Assessment Decision"), § 13 ("Services to Child and Family"); PR 19, § 6 ("Service Options").

support was far too little and far too late, considering the long-standing and well-documented risks to the family.

In light of CYFD's tepid approach, BCSO's Behavioral Health Unit (BHU)²⁵⁷ assumed primary responsibility for helping Alexis access services for her family. The NMDNJ spoke with the forensic case manager of BCSO's BHU. Although the unit had been working with Alexis since mid-December 2024, their involvement escalated after the incident in mid-February 2025 when Abraham Jr. and Charles were found with a loaded firearm. Alexis told BHU that she had been seeking assistance from CYFD for a "long time" without success. In response, BHU stepped in to fill the void—[connecting both Alexis and her children to critical services](#). For the children, BCSO BHU arranged high fidelity wraparound services through All Faith's Children's Advocacy Center, multi-systemic therapy, psychiatric outpatient programming, school-based clinical support, and other resources. For Alexis, BHU secured a forensic case manager, trauma-informed individual therapy, housing supports, and transportation assistance, among other resources.

After 10 years, 170 law enforcement dispatches and over 60 documented CYFD involvements,²⁵⁸ it is hard to fathom how the Department could view its responses as remotely adequate. Time and again, CYFD's own supervisors flagged the risks in child protective services' intake reports, including:

- October 22, 2018—"A child with concerning injuries and family has history of physical abuse resulting in injury."
- July 5, 2020—"Minor child(ren) not attended to and/or is left to care for him/herself and/or for younger siblings under circumstances which may result or has resulted in serious injury and/or death."
- December 3, 2022—"Threat of physical harm to a child due to domestic violence in the home where the caretakers cannot protect the child from harm. There is a history of abusive behavior that has been investigated and suggests a high chance of reoccurrence."
- January 24, 2023, and February 9, 2025—"Parent, guardian, or custodian has knowingly, intentionally, or negligently placed the child in a situation that may endanger the child's life or health."
- March 1, 2025—"Emergency – concerns of LOS [lack of supervision], the mother does not want the children in the home and is escalated. [T]he home may be immediately dangerous."

²⁵⁷ The BHU works to connect residents living with mental illness with appropriate services through collaboration between law enforcement and the community, specialized responses, and training.

²⁵⁸ See [NMDNJ's graphic](#) illustrating all law enforcement and CYFD involvement in Alexis D's family.

- July 11, 2025—“[C]oncerns for the safety of the children” and “concerns for sexual abuse.”

Timely intervention by CYFD could have prevented years of trauma, including Abraham Jr. and Charles witnessing domestic violence, their near-fatal encounter with a loaded firearm, and the sexual abuse of an infant. Instead of taking decisive action, the Department abdicated its responsibility, and substituted temporary safety plans and unenforceable referrals for the meaningful solutions Alexis’ children urgently needed. This exposed the children to intensifying danger and forced law enforcement to step into the protective role that CYFD was obligated—and failed—to fulfill.

CYFD’s resistance to partnering with law enforcement has created substantial gaps in child protection. Despite policies requiring close collaboration, the Department routinely obstructs holds, dismisses credible safety concerns, and undermines criminal investigations. This breakdown not only erodes trust between agencies but leaves children in dangerous environments, perpetuating cycles of harm that could have been prevented through coordinated action.

E. Systemic Failure: Devaluation of Foster Parents

“People come to me all the time and ask to be foster parents. I’m like, that’s the most volatile thing you can do, because if [CYFD] doesn’t like you, they can take your kids and there’s nothing you can do.”²⁵⁹

These are the candid words of a foster parent who spoke with the NMDOJ. They capture the frustration and deep mistrust that many foster parents feel when trying to work with CYFD.

The dynamic between foster parents and CYFD is often marked by a stark power imbalance, persistent mistreatment, lack of support, and retaliation. Foster families routinely feel powerless and undervalued. Based on the NMDOJ’s investigation, foster parents are treated more like disposable babysitters than trusted allies in promoting safety and stability for children in state care. Despite CYFD’s stated commitment to strengthening the foster care network, its strategies have largely failed to deliver meaningful results, exacerbating placement shortages for children who have experienced abuse or neglect.

²⁵⁹ NMDOJ interview with A.P. and L.P., Trans. 59:25-60:3 (May 23, 2025).

1. CYFD continues to fall short in meeting its foster family recruitment and retention goals.

a. Historical shortage and turnover of foster families.

As part of the *Kevin S.* settlement agreement, the Co-Neutrals²⁶⁰ established an annual requirement for CYFD to license a specific number of culturally reflective foster homes. According to the Co-Neutrals' 2023 and 2024 annual reports, CYFD's recruitment target of newly licensed non-relative resource homes was 190 in 2023 and 265 in 2024. CYFD fell short of these benchmarks—licensing 129 homes in 2023 (68% of the target) and 212 homes in 2024 (80% of the target).²⁶¹

In June 2024, CYFD acknowledged both the shortage of foster care applicants and the ineffectiveness of its recruitment efforts, noting that over 120 recruitment events yielded only 19 new inquiries from potential resource families.²⁶² As of September 2024, CYFD reported a total of 1,066 active resource homes.²⁶³

Since then, CYFD has continued to fall short of the Co-Neutral's performance standards. By March 2025, data provided by the [PSD data evaluation unit](#) shows the total number of resource homes at 1,059—a net loss from six months earlier.²⁶⁴ The significant gap between the number of children in state custody—2,164 as of March 2025²⁶⁵—and the availability of foster homes has resulted in foster parents being stretched beyond capacity and unable to provide the attention and support every child deserves.

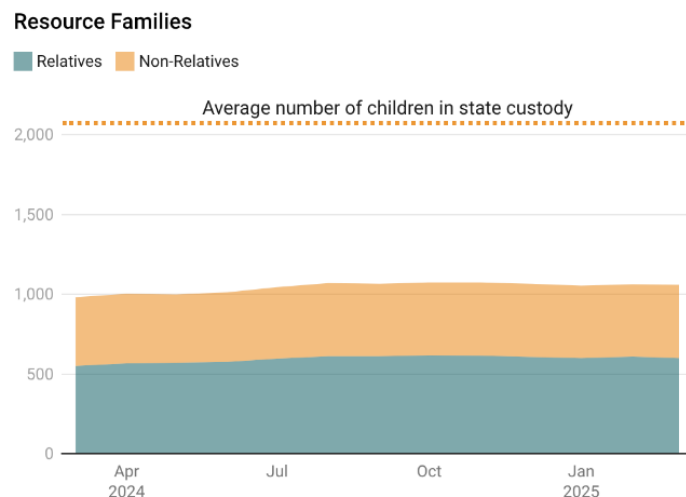


Figure 21. Number of relative and non-relative resource (foster) families in New Mexico, March 2024-March 2025. Reproduced from CYFD's March 2025 Data Evaluation Unit report.

²⁶⁰ *Kevin S. Settlement Agreement* at 5.

²⁶¹ Judith Meltzer and Kevin Ryan, *Co-Neutrals' 2023 Annual Report: Kevin S., et al. v. Blalock and Scrase* 100, Center for the Study of Social Policy (Nov. 15, 2024); *Kevin S. Co-Neutrals' 2024 Annual Report* at 93.

²⁶² LFC Report on Child Maltreatment at 7.

²⁶³ *Id.* at 2.

²⁶⁴ CYFD March 2025 Report at 3.

²⁶⁵ *Id.* at 2.

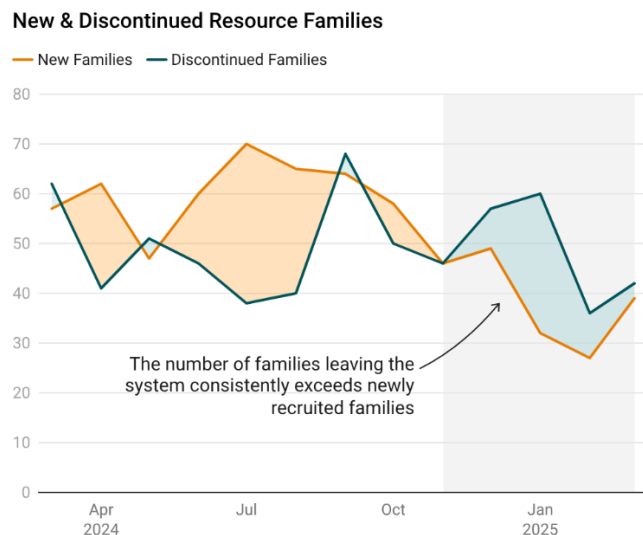


Figure 22. New and discontinued resource families, March 2024–March 2025. Reproduced from CYFD’s March 2025 Data Evaluation Unit report.

CYFD’s recruitment efforts have been offset by high rates of turnover. Between March 2024 and March 2025, CYFD’s recruitment gains were largely neutralized by the number of foster families leaving the system. In that time, there were an average of 52 new families per month, while an average of 49 families discontinued their licenses each month.²⁶⁶

According to the [Kevin S. Co-Neutral Team Resource/Foster Parent Interview Summary](#) from 2024 and 2025, 26% of foster parents interviewed stated they did not plan to renew their

foster parent license with CYFD. A majority cited frustration with the Department as a reason for nonrenewal.²⁶⁷

b. Unrealized recruitment strategy.

In June 2023, CYFD agreed to a [Corrective Action Plan](#) (CAP) to implement measures aimed at achieving compliance with the *Kevin S.* settlement agreement. As part of this CAP, CYFD committed to, among other steps: (1) assigning a dedicated placement staff member to focus exclusively on foster family recruitment in six high-needs counties (Bernalillo, Doña Ana, Santa Fe, San Juan, and Chavez/Eddy), and (2) entering into contracts with at least one private provider for resource family recruitment.²⁶⁸

In mid-2024, however, *Kevin S.* plaintiffs sought arbitration with CYFD and HSD, asserting that the two agencies violated the CAP and failed to meet performance standards outlined in the final settlement agreement. The claims focused on four key areas, including the lack of resource family recruitment. Arbitration was held in late 2024, and a [Decision and Award](#) was issued on January 21, 2025. The arbitrator found that CYFD did not meet their foster family recruitment obligations.

CYFD failed to assign staff that would exclusively focus on foster care recruitment in the six high-needs counties. Secretary Casados told the *Kevin S.* arbitrator that staffing

²⁶⁶ *Id.* at 2.

²⁶⁷ Co-Neutral Team Resource/Foster Parent Interview Summary, at 4 (Apr. 30, 2025).

²⁶⁸ Kevin S. Corrective Action Plan for Partial Resolution of Issues in Dispute, at 3, *Kevin S. v. Blalock, et al.*, No. 1:18-cv-00896 (D.N.M. June 30, 2023).

vacancies prevented the Department from dedicating a licensing and support specialist solely to recruitment. In Santa Fe County, the recruiter also served as a permanency placement supervisor. In Doña Ana County, the staff member was responsible for recruiting in seven other counties. In Bernalillo County, the recruiter left and was not replaced. Each staff member confirmed they had significant responsibilities beyond recruitment, including adoption disclosures, training resource parents, and supervising children in CYFD offices.²⁶⁹

Further, although CYFD contracted with Jonathan Salazar on July 12, 2023, to help increase foster home capacity, his work did not result in any measurable increase in foster home capacity statewide.²⁷⁰ Secretary Casados was unable to confirm whether Mr. Salazar was vetted prior to his hiring, but she told the arbitrator that he was hired in part due to Secretary Casados' prior working relationship with Mr. Salazar's mother.²⁷¹

As part of his contract, Mr. Salazar met with staff in CYFD county offices throughout the state to analyze and develop a recruitment plan. Mr. Salazar discovered that CYFD's data collection procedures for identifying interested foster families were disjointed and inconsistent. For example, some county offices were tracking or capturing data with handwritten notes, while others were using excel spreadsheets.²⁷² Another primary barrier was the 3 to 6 month licensing timeline for foster families, which contributed to a significant backlog.²⁷³ Mr. Salazar attempted to address the issue by introducing the "spider-web" model, where a host family invites friends, family, and colleagues to learn about fostering, and an incentive program offering financial rewards for successful referrals.²⁷⁴ Ultimately, however, CYFD did not see notable benefits from the spider-web model. Salazar attributed the lack of success to CYFD's inability to offer incentive payments to foster parents hosting events.²⁷⁵

c. Ongoing planning and implementation challenges.

Despite assurances of a more targeted recruitment strategy, the *Kevin S. Co-Neutrals* noted in their September 2025 report that "CYFD has not consistently implemented a coordinated plan or effective strategies to recruit, license, and retain non-relative foster

²⁶⁹ *Kevin S. Arbitration Decision and Award* at 20–21; *Co-Neutrals' 2023 Annual Report* at 102.

²⁷⁰ *Id.* at 24.

²⁷¹ Trans. Teresa Casados 164:25-167:25 (Day 8 of Arbitration), *Kevin S. v. N.M. Children, Youth and Families Dep't.* (Nov. 22, 2024) (hereinafter "Casados Trans.").

²⁷² Trans. Jonathan Salazar 84:5-12 (Day 5 of Arbitration), *Kevin S. v. N.M. Children, Youth and Families Dep't.* (Nov. 8, 2024) (hereinafter "Salazar Trans.").

²⁷³ *Kevin S. Arbitration Decision and Award* at 21–22.

²⁷⁴ Salazar Trans. at 88:15-23 (Day 5 of Arbitration) (Nov. 8, 2024).

²⁷⁵ Casados Trans. at 259:21-24 (Day 8 of Arbitration) (Nov. 22, 2024).

families.”²⁷⁶ According to this report, although CYFD sought to complete all licensing within 120 days of a family’s application, roughly 25% of those applications were still pending between 120 and 250 days after submission.²⁷⁷

Throughout 2025, CYFD licensed 122 new non-relative foster homes—46% of the annual target—including 83 homes in six high-needs counties.²⁷⁸ Additionally, the statewide annual target for new treatment foster care placements²⁷⁹ was 244, and through November 2025 CYFD had licensed 121 placements—just under 50 percent of that goal.²⁸⁰

The Co-Neutrals raised additional concerns with CYFD’s strategies to recruit and develop new leads for prospective foster families, including: (1) an unclear approach toward recruitment and retention events; (2) questionable timing and content of orientation sessions; (3) poorly coordinated training, scheduling problems, and inconsistent access to materials; and (4) underutilization of an expanded contract with All Faith’s to complete non-relative home studies due to insufficient referrals.²⁸¹

CYFD has touted its new Foster Care Plus program—a program modeled after Oklahoma’s efforts to expand family-based therapeutic placements—as a potential solution to foster placement availability. However, CYFD’s Foster Care Plus program has not been timely implemented. By September 2025, after months of requests, the Co-Neutrals had not received any documentation supporting CYFD’s progress toward developing this program.

Overall, CYFD’s ongoing failure to advance effective foster home recruitment and retention strategies, combined with inefficient use of available resources, continues to prevent the Department from meeting its commitment to expand the foster care network.

²⁷⁶ Judith Melzer and Kevin Ryan, [*September 26, 2025 Kevin S. Report re October 7, 2025 Arbitration Status Hearing: Attachment C, Co-Neutrals Assessment of CYFD’s Efforts to License New Non-Relative Resource Homes January through August 2025*](#), Center for the Study of Social Policy (Sept. 26, 2025), at 2.

²⁷⁷ September 26, 2025 Kevin S. Report. Attachment C, at 5.

²⁷⁸ Judith Melzer and Kevin Ryan, [*January 30, 2026 Kevin S. Report re March 2, 2026 Arbitration Status Hearing*](#), Center for the Study of Social Policy (January 30, 2026), at 7.

²⁷⁹ 7.20.11.29 NMAC. Treatment foster care services are targeted to children who have complex and difficult psychiatric, psychological, neurobiological, behavioral, and psychosocial problems.

²⁸⁰ January 30, 2026 Kevin S. Report, at 8.

²⁸¹ September 26, 2025 Kevin S. Report. Attachment C, at 6-8.

2. CYFD violates the Foster Parent Bill of Rights and retaliates against foster parents.

The [New Mexico Resource/Foster Parent Bill of Rights](#)²⁸² outlines 24 basic rights and expectations of foster families in caring for children in CYFD custody. Among these rights, foster parents are entitled to:

- Be treated with dignity, respect, and consideration as integral members of the child welfare team;
- Provide input concerning the plan of services for children in their care and have that input given full consideration, in the same manner as information presented by other members of the team, without retaliation;
- Be free from acts of harassment and retaliation by CYFD staff; and
- Be informed of and receive available support services for a child in their care, as provided by CYFD policy and procedure.²⁸³

The NMDOJ interviewed 25 foster parents who shared a variety of troubling experiences with CYFD's treatment and practices. These accounts revealed that CYFD has created a culture of fear and distrust and often fails to uphold the rights guaranteed under the Resource/Foster Parent Bill of Rights.

Four issues were prominent among the foster parents interviewed: (1) absent or poor communication, (2) insufficient support for accessing medical and behavioral health services, (3) deficient record-keeping practices, and (4) suppression of foster parent advocacy and retaliation.

a. Poor communication with foster parents.

Foster parents universally cited the lack of communication from CYFD as a significant challenge. They noted that attempts to contact CYFD rarely result in reaching the intended PPW without repeated efforts—a difficulty worsened by outdated phone directories and frequent staff turnover. Foster parents also reported that PPWs often failed to communicate with families about required monthly home visits. One family reported that, as of May 2025, they received no communication from their assigned PPW since December 2024, and another since October 2024.²⁸⁴ In both cases, CYFD violated state regulations by failing to

²⁸² CYFD, [New Mexico Resource/Foster Parent Bill of Rights](#) (2025); see also 8.26.2.11 NMAC. Additionally, foster parents have a statutory right to intervene in legal proceedings regarding a child in their care for at least six months. See NMSA 1978, § 32A-4-27(A)(1).

²⁸³ *Id.* (Rights # 1, 3, 10, and 17).

²⁸⁴ NMDOJ interview of A.P. and L.P. (May 23, 2025); NMDOJ Interview with M.M. (May 27, 2025).

timely assess whether the child's placement was meeting their emotional and physical needs.²⁸⁵

One foster parent, C.Y., recalled feeling pressured to accept more children than she could reasonably care for. She apprehensively accepted more children after CYFD assured her the placement would be short-term. That placement involved four siblings, increasing the number of children in her home to 14. However, once the children were placed, CYFD ceased communication for an extended period of time and provided no information about the children's needs or how long they would remain in her care.²⁸⁶

Several foster parents expressed concern over CYFD's failure to disclose critical medical and behavioral information about children prior to placement, in violation of the Resource/Foster Parent Bill of Rights. One foster parent reported that she was given minimal background on a child with a known history of violence, which ultimately led to her being physically injured.²⁸⁷

CYFD's communications were more than just inconsistent or absent—the Department often gave foster parents information that was misleading or outright false. Foster parents A.P. and L.P. described an incident where CYFD placed a 13-year-old girl in their home, expressly claiming the child did not have any history of perpetrating abuse. Despite those assurances, the teen immediately began exhibiting sexually aggressive and inappropriate behavior toward other young foster girls in the home. When the 13-year-old attempted to engage in sexual acts with another child in A.P. and L.P.'s home, they requested to have her removed. Upon pickup, the CYFD PPW told L.P. that “we just needed proof,” implying that the Department had knowledge of the 13-year-old's sexual misbehaviors prior to placement. L.P. recalled thinking: “You used my freaking kids as bait with a sexual predator? . . . You guys have got to be out of your minds.”²⁸⁸

Every foster parent who spoke with the NMDOJ shared multiple examples where CYFD's failure to communicate had direct and harmful consequences for children in their care. One parent described how a doctor was forced to alter a child's medication without CYFD's consent after repeated attempts to reach the Department went unanswered. Another recounted how children missed a long-planned vacation because CYFD ignored months of requests to obtain passports. Repeated lapses in communication have left many foster parents feeling unsupported and undervalued. As foster parent R.H. told the NMDOJ:

²⁸⁵ 8.10.8.19 NMAC.

²⁸⁶ NMDOJ interview of C.Y. (May 29, 2025).

²⁸⁷ Id.

²⁸⁸ NMDOJ interview of A.P. and L.P. (May 23, 2025). L.P. filed SCI reports after each incident of sexual aggression, but CYFD claimed there was no record of the reports.

“My first placement worker [PPW] told me that that I was a glorified babysitter and I needed to learn my place, and luckily I don’t have her anymore.”²⁸⁹

b. Insufficient support in accessing medical and behavioral health services.

To ensure children in state custody receive medical and behavioral health services, CYFD must work in close coordination with foster parents—who, as the primary caregivers, are best positioned to recognize and advocate for the needs of the children in their daily care. Far too often, however, foster parents note that CYFD complicates access to critical services, acting more as a barrier than an ally in meeting children’s needs. Foster parent B.R. told the NMDOJ that CYFD consistently overpromises and underdelivers, often failing to provide the essential resources foster families are led to expect. She stated:

“CYFD chronically over promises to foster parents what their resourcing will be. That’s a huge problem. You know, you can’t tell foster parents, well, we’re going to give you this support and we’re going to give you that support . . . and then do nothing.”²⁹⁰

As the legal custodian for children in state care, CYFD is responsible for authorizing necessary healthcare services. Yet, as one foster parent and early intervention provider explained, delays often occur because CYFD’s PPWs are unavailable to sign necessary documents, forcing children to wait for critical care, medication, and therapy.²⁹¹ Foster parent R.H. described taking her foster child to the emergency room during a severe mental health crisis, only to face prolonged delays because CYFD was unavailable to sign the necessary admission documents. R.H. stated:

“I had to take [the child] to the emergency room because she told me she was hearing voices. They [the voices] were telling her to kill me, kill her sister. I called CYFD the moment we were headed to the ER and six hours later, the ER is still calling CYFD. I’m calling CYFD, I’m texting our worker [PPW]. The worker on call saying we don’t have enough people to come and sit with your kid at the ER. And I said I don’t need you to sit with her. I need you to sign papers for her to be admitted. You can even just tell them verbally, they’re trying to get a hold of you. They ended up having to involuntarily commit her. We were there all day waiting for CYFD to give the go ahead.”²⁹²

²⁸⁹ NMDOJ interview of R.H. (May 30, 2025).

²⁹⁰ NMDOJ interview of B.R. (May 29, 2025).

²⁹¹ NMDOJ interview of C.Y. (May 29, 2025).

²⁹² NMDOJ interview of R.H. (May 30, 2025).

R.H. also discussed a prior incident where they had to pick up a different foster child from the psychiatric unit because the hospital refused to release the child to CYFD caseworkers due to their past unreliability. Medical staff insisted on discharging the child only to a foster parent, citing past instances where, after being released to CYFD employees, the child missed medications and follow-up appointments, leading to repeated readmissions.

Other foster parents cited multiple instances where CYFD hindered access to care for children in their custody, including:

- M.M. spent months unsuccessfully seeking assistance from a CYFD PPW to resolve her foster child's dental issues and obtain approval for braces;
- L.K. contacted CYFD for help obtaining glasses for a foster child with vision issues but encountered resistance from the assigned PPW;
- While fostering a teenager, C.Y. received medication from a PPW in an unmarked package—without bottles, labels, or dispensing information. C.Y. had to separate the pills and research the dosing instructions herself.

Other times, CYFD PPWs lacked awareness of appropriate resources for children in foster care. According to A.P. and L.P., many newer PPWs were unfamiliar with community services and often learned about options from foster parents themselves. When A.P. and L.P. sought behavioral health services for their two foster daughters who had experienced years of abuse, their PPW stated, "I googled it and couldn't find anything."²⁹³ L.P. questioned why CYFD did not maintain a centralized list of pediatric services. Foster parent B.R. confirmed that CYFD PPWs often lack knowledge of available services, attributing this to unmanageable caseloads. She explained, "[T]hey absolutely have no idea of where to get the resources to help them."²⁹⁴

c. Deficient record-keeping practices.

CYFD's record-keeping practices were consistently described by foster parents as lacking organization, completeness, and accuracy. Foster parent A.P. explained that CYFD PPWs routinely lacked critical identifying information, such as Social Security numbers, for children in their custody. Similarly, others reported that CYFD often placed children in homes without knowing their full names, dates of birth, or medical and behavioral histories. In one case, a foster parent was unable to fill a child's prescription because CYFD could not locate the child's insurance information. Such lapses delay necessary care and place an

²⁹³ NMDOJ interview of A.P. and L.P. (May 23, 2025).

²⁹⁴ NMDOJ interview of B.R. (May 29, 2025).

undue burden on foster parents to navigate the child's urgent needs without basic information.

In addition to missing personal identifiers, CYFD frequently loses or fails to provide critical medical documentation. Foster parent J.R. recounted being unable to obtain medical records from CYFD, preventing J.R. from timely securing an EpiPen for a child in her care, despite repeated efforts. Others shared similar frustrations. One foster parent could not access medical records for a child on the autism spectrum. Another waited six months for birth certificates needed to enroll children in school. In one particularly troubling case, CYFD lost all documentation required for the full disclosure process, delaying an adoption for a child in state custody. These failures reflect a broader trend of disorganization and administrative dysfunction that impedes the delivery of vital services to children in foster care.

d. Retaliation and suppression of foster parent advocacy.

Foster parents often described their interactions with CYFD as coercive. They reported that advocating for children in their care or raising concerns about Department practices could trigger retaliatory actions, including removal of children from their home without clear justification. In many instances, CYFD leveraged the power imbalance to suppress contrary opinions and pressure foster parents into silent compliance.

i. Retaliation after complaints about CYFD:

In several examples discussed with the NMDOJ, CYFD threatened or took adverse action against foster parents after they lodged complaints about departmental practices or PPW decisions. Foster parents A.P. and L.P. reported that, before CYFD's statutes were changed to require advance notice of placement changes,²⁹⁵ CYFD would often move children abruptly and without explanation—particularly when a foster parent expressed views or took actions that a PPW found objectionable. Foster parent A.P. recalled one instance where CYFD picked a child up directly from school and placed with them with a new family shortly after A.P. told the PPW they were being inconsiderate with her time. CYFD did not allow the child to see or say goodbye to A.P. or L.P., and did not pick up the child's belongings from their home.

On another occasion, PPWs threatened to remove children from A.P. and L.P.'s home after they made a formal complaint about CYFD's conduct to the Attorney General. When A.P. and L.P. made the complaint, CYFD immediately began efforts to identify a new placement for the family's four-year-old child, offering an apparently pretextual reason that

²⁹⁵ NMSA 1978, § 32A-4-14.

the child may have had Native American heritage, and thus required an ICWA-preferred home. Of course, it is extremely unlikely that CYFD’s decision to seek a new placement for the child coincidentally occurred on the very same day A.P. and L.P. made their complaint. Indeed, it was later confirmed that the child was not Native American and had been placed appropriately. A.P. and L.P. expressed deep frustration with the lack of any meaningful avenue for addressing CYFD misconduct. In their experience, CYFD’s Office of Constituent Affairs offered no real accountability or solutions. As A.P. put it, she would “never be dumb enough [to make a constituent complaint] because the only thing that comes from that is retaliation.”²⁹⁶

CYFD routinely dismisses legitimate foster parent concerns, viewing them as challenges to authority rather than opportunities for improvement. This approach often leads to adversarial relationships and punitive decision-making. As foster parent J.R. put it, “if those [CYFD] supervisors get mad, that’s it. Your life will be a living hell.”²⁹⁷

ii. Retaliation triggered by parent advocacy and requests for support:

According to several foster parents interviewed by the NMDOJ, CYFD often treated their advocacy and requests for support as nuisances to be managed rather than contributions to the foster child’s well-being. According to foster parent R.H., CYFD retaliated by removing her child after R.H. was perceived as high-maintenance by the Department. R.H. voiced concerns to CYFD about school bullying and troubling sexual behaviors after parental visits, and as a result, her foster daughter was removed to a treatment foster care setting for nearly 18 months. Before transferring divisions, R.H.’s outgoing PPW openly admitted the child’s removal was directly tied to R.H.’s willingness to speak up. Rather than consider the additional trauma removal would have on the child, [the PPW explained](#) how the decision was ultimately easier on CYFD:

“You were asking for a lot. And it was getting to be too much for us. And it was just easier for us to move them to TFC [treatment foster care] and do what we wanted to do because you were raising so many concerns . . .”²⁹⁸

Foster parents also described instances where CYFD removed children after the foster parents requested basic support—such as help with transportation or access to therapeutic services. This dismissive treatment also applied to service providers themselves. C.Y., who works at an early intervention agency, explained that if she advocates too much for foster children to receive certain services, she “will get a letter from CYFD that

²⁹⁶ NMDOJ interview of A.P. and L.P. (May 23, 2025).

²⁹⁷ NMDOJ interview of J.R. (May 5, 2025).

²⁹⁸ NMDOJ interview of R.H. (May 30, 2025).

[the child] no longer needs services through your agency.”²⁹⁹ Other parents feared requesting a level of care reassessment³⁰⁰ for their child, worried that CYFD would interpret the request as an acknowledgement that they were unfit to parent.³⁰¹

CYFD has also responded negatively when foster parents questioned placements that exceeded their capacity. C.Y. told the NMDOJ that she was once asked to take in additional children, despite already caring for ten in her home. When she questioned whether she could adequately meet the needs of so many children, CYFD warned that taking an extended break from accepting more foster placements could jeopardize her license.

iii. Retaliation for perceived opposition to reunification:

Foster families commonly reported that CYFD retaliates—often through threatened or actual removal of children—when their advocacy is misinterpreted as opposition to their child’s reunification with biological families. In one case, L.K., a foster parent who had cared for a child for three years, raised concerns after the child returned from overnight visits with her biological father with injuries and burns. L.K. sought to intervene in Children’s Court to address the safety of these visits and the timeline for reunification. Instead of responding to the risks brought to light by L.K.—or recognizing that her actions were motivated by the child’s well-being rather than an attempt to derail reunification—CYFD responded by threatening legal action and removal of the child.³⁰²

In another case, a dispute arose between foster parent C.Y. and a CYFD PPW over C.Y.’s perceived lack of support for reunification. In fact, as both a resource parent and early intervention services provider, C.Y. actively encouraged the development of a healthy relationship between the biological family and the child. However, at one point during the pendency of the abuse and neglect proceeding, the biological father threatened to kill C.Y. and blow up her home. Despite the death threat, the PPW pressured C.Y. to increase contact and activities with the biological family—an expectation she understandably resisted. The PPW misinterpreted C.Y.’s reasonable caution as opposition to reunification. The PPW later told a colleague—unaware that the colleague was also a friend of C.Y.—that C.Y. was a

²⁹⁹ NMDOJ interview of C.Y. (May 29, 2025).

³⁰⁰ CYFD Permanency Planning Proc. PR 10, § 14 (“Level of Care Assessment”). Children’s care levels—ranging from Level 1 to Level 3—reflect the degree of support and supervision they need, with Level 3 representing the most intensive. PPWs may reevaluate and adjust this classification at any point.

³⁰¹ NMDOJ interview of B.R. (May 29, 2025); NMDOJ interview of C.Y. (May 29, 2025).

³⁰² Under NMSA 1978, Section 32A-4-27, a foster parent who has cared for a child for at least six months may seek to intervene in an abuse and neglect proceeding. In L.K.’s case, she was ultimately granted guardianship over the child after the father was found using substances in the home.

“bitch,” and “was going to do everything she could to remove the foster child from her [C.Y.’s] home.”

Foster parents Brianna B. and Amy M., who live in separate homes and care for siblings Valerie and Cory, respectively, also shared their experiences with CYFD retaliation. In early 2025, Brianna and Amy filed multiple SCI reports after both children returned from unsupervised visits with their biological father with bruises and independently disclosed physical abuse. When a BCSO detective recommended pausing visits due to a criminal investigation against the biological father, Brianna withheld Valerie from one visit. In response, a CYFD supervisor—who was already under an internal investigation after prior misconduct toward Brianna—ordered an immediate placement change without sufficient basis, which was later reversed after a CYFD legal review. Amy corroborated the threatened removal and expressed fear about filing future SCI reports, noting that “it’s well known how the Department retaliates.” This was yet another example of CYFD choosing to assert dominance over foster parents instead of confronting serious threats to a child’s health and safety.

Additional concerns reported by foster parents included: (1) inconsistent support with school transportation, (2) untimely reimbursements, (3) PPW unpreparedness in court, resulting in permanency delays, and (4) PPWs misrepresenting treatment plan progress of biological parents to justify premature reunifications.

The NMDOJ recognizes that frontline CYFD caseworkers are often not solely to blame for the deterioration of relationships between foster parents and the Department. Several former CYFD employees explained to the NMDOJ that they often expressed a desire to work constructively with foster parents but were directed by their supervisors to adopt a more punitive and adversarial stance. CYFD’s approach undermines foster parent engagement, hinders its ability to recruit and retain a robust resource family network, and negatively impacts the quality of care that children in state custody receive.

3. The *Kevin S. Co-Neutrals*’ interviews corroborate NMDOJ’s findings

Between mid-2024 and early-2025, the *Kevin S. Co-Neutrals* conducted virtual interviews with 92 foster parents in New Mexico. Their conclusions closely mirrored those of the NMDOJ’s in several key areas:

- Foster parents felt underappreciated by CYFD, with some expressing that they were treated more like babysitters than equals;
- 83% of foster parents reported wanting more details about children being placed in their home, including medical and behavioral histories. Some resource families

felt that caseworkers intentionally withheld critical information that might dissuade them from accepting placements;

- Caseworkers were frequently unresponsive, sometimes taking days or weeks to reply to requests for information or support;
- Caseworkers misled foster parents about the status of a child's availability for adoption, leading to feelings of distrust;
- Foster parents shared experiences of subtle retaliation for raising concerns or making requests for support services.³⁰³

4. CYFD discourages foster parent networks and support groups.

In the absence of meaningful support from CYFD, foster parents have increasingly turned to one another for direction, resources, and community. Maralyn Beck—the founder and executive director of New Mexico Child First Network—works to help fill the void left by CYFD, providing foster families the guidance and advocacy the Department has failed to furnish. Ms. Beck established the Child First Network to offer support groups, events, and tools for foster parents that empower them with trauma-informed training and mentorship.

The New Mexico Child First Network supports foster families through community-based initiatives, including a monthly support group and a social media platform for exchanging essential childcare items. These efforts ease the practical burdens of fostering and create a sense of solidarity and empowerment among resource families. Ms. Beck's organization also operates a private Facebook group of over 600 foster parents, providing a space for caregivers to share experiences and seek insights without fear of retaliation. The group intentionally excludes CYFD staff, allowing for open discussion of challenges and concerns. Many foster parents are reluctant to ask CYFD caseworkers questions directly, fearing it could be seen as weakness or risk the removal of children from their care. However, foster parents have reported to the NMDOJ that CYFD staff have attempted to infiltrate the group using fake profiles to monitor criticism, further deepening mistrust and reinforcing the need for independent, peer-led support networks.

Rather than embrace foster parent support groups as useful forums to achieve shared child welfare goals, CYFD often undermines them. Reports to the NMDOJ indicate that during Resource and Adoptive Family Training (RAFT), caseworkers have actively discouraged new foster parents from engaging with these networks. Community-created support groups clearly enhance the experience of foster families, and by extension, the children in their care. CYFD's efforts to limit their influence suggest a strategy—not of collaboration, but of control—aimed at suppressing open dialogue and isolating foster

³⁰³ 2024–25 Co-Neutral Team/Resource Foster Parent Interview Summary pp. 2–3, 15, 33, 35.

parents from one another. Instead of resisting these groups, the Department should engage constructively with them to amplify their impact and better meet the real-world needs of foster families.

Foster families are the backbone to New Mexico’s child welfare system. CYFD’s failure to respect and involve foster parents has consequences that ripple far beyond individual households. When resource families leave the system due to mistreatment, lack of support, or retaliation, the entire foster care framework is destabilized. Fewer available homes gives CYFD a built-in excuse for failing to remove children from unsafe environments and encourages premature reunification with biological parents. At the heart of this breakdown is CYFD’s culture and attitude toward foster parents: It treats foster parents not as partners, but often as expendable babysitters. Until CYFD treats foster families with dignity, fairness, and professionalism, it will remain unable to rebuild trust and ensure the safety and stability that children in state custody deserve. As foster parent L.K. put it plainly:

“It is 1000% because of CYFD that they don’t have more foster parents. They quit because of CYFD.”

F. Systemic Failure: Excessive Placements

Placement instability within the foster care system disrupts consistency in a child’s upbringing and hinders the development of secure attachments essential for healthy growth. Under the *Kevin S.* settlement agreement,³⁰⁴ CYFD was obligated to ensure that by December 1, 2022, children in CYFD custody do not experience more than three placements in out-of-home care per 1,000 days. CYFD has never come close to meeting that obligation, and the rate of placement moves in 2024 was the highest since 2019.³⁰⁵ Children in CYFD custody—many already deeply traumatized by the circumstances leading to their removal—often endure frequent and unnecessary placement changes.

The most recent federal data demonstrates that children in New Mexico are “experiencing placement moves at a rate nearly double that of the nation as a whole. National performance is 4.48 moves per 1,000 days in care, while the most recent data profile issued in February 2025 shows that children in New Mexico experience 8.52 moves per 1,000 days in care.”³⁰⁶ The rate of placement changes has become exponentially worse in recent years. New Mexico’s Substitute Care Advisory Council (SCAC), an independent group that evaluates the extent to which CYFD is effectively discharging its child protection

³⁰⁴ *Kevin S. Settlement Agreement* at 7a (Appendix B, Target Outcome No. 8).

³⁰⁵ *Kevin S. 2024 Co-Neutrals’ Annual Report* at 102.

³⁰⁶ CFSR 2025 New Mexico Final Report at 4.

responsibilities, corroborates this trend. The SCAC’s FY 2025 Interim Report notes that of the cases it reviewed, the number of placements for children in state custody ranged from 2 to 114.³⁰⁷ The report found that New Mexico has the highest percentage of children with two or more placements per 1,000 days in the country.³⁰⁸

The NMDOJ spoke extensively with two children who were in CYFD custody for a combined 16 years and eight months: Jacob L. and Emma G. Jacob experienced over 30 placements during his five years and eight months in custody—or 10 times the threshold established by the *Kevin S.* settlement. Emma experienced over 20 placements during her 11 years in CYFD custody—seven times the threshold established by the *Kevin S.* settlement. This investigation also examined the case of Aliyah M., a teenager who died by suicide while in CYFD custody after enduring a series of destabilizing placement changes in a short span of time. All names used herein are pseudonyms, but each account documents the real experiences of children who lived through these destabilizing circumstances in state custody.

1. Case Study: “Jacob L.”

Jacob entered CYFD custody at the age of 12 after his adoptive father, Sean L., was found to be unable to care for him due to a chronic alcohol addiction. Upon entering state custody, Jacob had several diagnosed mental and behavioral health conditions requiring prescription medication. In 2016, the Children’s Court documented the following:

3. MENTAL AND PHYSICAL HEALTH OF:

a. The children:

██████ is currently diagnosed with Conduct Disorder, Attention Deficit Hyperactivity Disorder Combined Presentation, Reactive Attachment Disorder, R/O Disruptive Mood Dysregulation Disorder. ██████ came into CYFD custody taking the following medications which were prescribed by Children's Treatment Center psychiatrist, Dr. White: Oxcarbazepine 2x day and Clonidine 2x day.

State regulations and CYFD policy required the Department to complete a level of care assessment to ensure that Jacob would be placed in an environment capable of meeting his unique needs. CYFD repeatedly failed to place Jacob in a foster care setting that guaranteed Jacob’s physical and mental well-being.

CYFD shuffled Jacob to eight different placements during his first two months in custody. Jacob’s initial placements—congregate care and group home facilities—were marked by frequent abuse and neglect. CYFD should have promptly investigated these

³⁰⁷ Substitute Care Advisory Council, *SFY 25 Interim Report to CYFD, Courts, & Legislative Interim Committees* 9-10 (June 6, 2025).

³⁰⁸ *Id.* at 9.

issues, sought corrective action within the facilities, and taken more proactive steps to support Jacob. Instead, CYFD completely abdicated its responsibility to safeguard his safety.

During Jacob's interview with the NMDOJ, he recalled that upon entering custody, he stayed at Amistad Shelter for Youth. Amistad was severely understaffed, and Jacob's meals were sporadic and lacked nutrition, in violation of the New Mexico Foster Care Bill of Rights. Jacob was later placed at Casa Hermosa, an independent living facility designed for children 16 and older. Jacob was only 12 years old at the time of placement. CYFD set Jacob up to fail by placing him in an unstable environment with older peers, all while depriving him access to therapeutic services necessary to address his significant mental and behavioral health diagnoses.

Thereafter, Jacob experienced four brief placements in less than a month, ultimately leading to a placement at Bernalillo Academy. A CYFD PPW told Jacob that he would only be there for 24 hours to receive a behavioral health assessment. Contrary to CYFD's assertions, Jacob stayed at Bernalillo Academy for at least two weeks. He described the facility as "hell" and a "mini-jail." All children were required to walk in a single file line with their heads down at all times. Jacob—still 12 years old at the time—was required to share a room with a five-year-old. Jacob recounted that the staff at Bernalillo Academy would apply physical restraints and engage in aggressive tactics, such as forcing young children up against the wall. Jacob described the facility as dirty and noted that kids often sat in their own feces. While placed at Bernalillo Academy, Jacob was enrolled at a middle school in Albuquerque. Despite CYFD's legal obligation to ensure that Jacob's educational needs were met, CYFD PPWs stopped transporting Jacob to school.

After being discharged from Bernalillo Academy, CYFD placed Jacob at Desert Hills Residential Treatment Center for nine months beginning in October 2016. Consistent with his prior placements, Desert Hills ignored requirements to house children with others similarly aged, instead placing 12-year-old Jacob in a unit with 14- to 16-year-olds. Jacob was physically assaulted five times on his first day at Desert Hills. While he was being "jumped" by older children in Desert Hills, Jacob recalls seeing the program director walk away rather than intervene. Jacob was transported to the emergency room and was diagnosed with a concussion. Desert Hills made five attempts to contact CYFD to report the incident. Despite its legal and ethical obligations, CYFD failed to investigate the incident.

CYFD's PPW did not visit Jacob at the hospital or check on his well-being until nearly a week after the attacks. Thereafter, the PPW continually failed to communicate with Jacob in a timely and responsible manner. Under state regulations, Department policy, and the Foster Child and Youth Bill of Rights, PPWs are obligated to have, at a minimum, monthly

visitation with children in state custody.³⁰⁹ Jacob's PPW consistently failed to meet this minimum standard and left him to endure ongoing physical and psychological suffering.

While at Desert Hills, Jacob was repeatedly exposed to conditions that caused serious trauma. Staff at Desert Hills would arbitrarily move Jacob around to different pods (or living areas), including once placing Jacob in a unit designated for marked gang members, and later moving him to a unit for "problem kids" that staff did not want to deal with. Jacob described the staff at Desert Hills as being retaliatory—if he asked for something, however innocuous, or sought a change to his conditions at Desert Hills, staff would take away personal items.

Jacob often saw residents at Desert Hills fighting among themselves and reported that staff would often instigate those fights. Jacob recalled that Desert Hills staff often allowed residents at the facility to engage in physical fights for prolonged periods of time without intervention. Beyond the altercation on Jacob's first day at Desert Hills, he reported being physically harmed on at least three separate occasions. In one incident, Jacob reported to Desert Hills staff that other residents coerced him into stealing contraband from facility offices for use during a riot against staff. The conditions at Desert Hills drove Jacob to consider suicide on at least one occasion.

Jacob's time at Desert Hills mirrored that of many other children who entered the facility—he quickly learned that survival meant either acceptance of being victimized, or learning to act like a perpetrator. Despite the unsafe and distressing conditions, Jacob's PPW made no effort to remove him from his placement at Desert Hills. Even when Jacob's legal counsel asked CYFD to find Jacob a placement that would meet his physical and emotional needs, those pleas fell on deaf ears. Jacob recalls only being able to leave Desert Hills after Medicaid would no longer pay for his "treatment" there.³¹⁰

After leaving Desert Hills in the summer of 2017, Jacob's CYFD-directed nomadic experience continued. *He resided in 17 different placements within a 21-month period.*

³⁰⁹ PSD is required to visit each child at least monthly in the child's placement to assess for appropriateness in meeting the child's safety, emotional and well-being needs. 8.10.8.19(C) NMAC; CYFD Permanency Planning Proc. PR 19, § 11 ("Worker-Child Visits"); CYFD, [New Mexico Foster Child and Youth Bill of Rights](#) Right #10 (2023).

³¹⁰ Jacob is not the only child to suffer abuse and neglect at the for-profit Desert Hills and Bernalillo Academies. By 2021, both institutions had their licenses revoked following multiple critical incidents, including repeated violence, sexual abuse, numerous suicide attempts, and improper use of physical restraints by staff. See Ed Williams, [New Mexico Struggles to Follow Through on Promises to Reform Child Welfare System](#), Searchlight New Mexico (Oct. 7, 2022).

Jacob entered treatment foster care in late 2017, and upon departing in early 2018, CYFD placed him with a foster mom who already had two adopted children. Jacob described obvious favoritism in the home, noting that he was at times locked in his room and prevented from leaving. Jacob eventually left that residence and continued to be shuffled around to different homes and facilities. Throughout 2018 and 2019, he spent time in shelters across Taos, Roswell, and Hobbs, and ultimately ended up at New Day, a youth shelter in Albuquerque. As Jacob was moved from place to place, his PPW failed to show up for required monthly check-ins. During this period of frequent shifts in his living circumstances, Jacob's youth attorney served as his only steady source of stability and support, repeatedly pressing CYFD staff to meet their obligations to secure needed services and a suitable placement. In one such email correspondence, the attorney wrote to Jacob's PPW:

██████████

Thank you for letting me know. The phone has become ██████████ only way to continue and keep attachments to people. He has never been more in touch with me, for example, in the last few weeks, including reaching out when things got tough for him in Hobbs. He has no family, and no foster family who loves him.

We have to put our heads together and work as a team to figure out placement and services for ██████████. He trusts me and I am the only one left who has been on his case from the start.

I know he resists support. I also know he wants a family who accepts and loves him. The Department has a duty to shelter and care for each kid as they are; including tough ones like him. I really think we need to ask him what he wants and we need to listen. I will do what I can to set this up.

After leaving New Day, Jacob continued experiencing placement instability. At one point, he was told by a PPW that CYFD could not find a placement for him, and the PPW asked Jacob if he could find his own place to stay. Of course, this was an inappropriate request for any minor in state custody, let alone Jacob, who at 15-years-old had been repeatedly shuttled across the state to numerous facilities lacking any semblance of a family-based environment.

In the summer of 2019, Jacob began living at the CYFD office building in Albuquerque. Jacob reported inadequate living conditions at the office. For example, he explained that a storage closet was often the only place for him to sleep. He regularly only ate bags of goldfish and drank bottled water, as CYFD employees who were watching Jacob told him that gift cards to fast food restaurants must be used sparingly. On some nights, Jacob wasn't allowed to stay at the CYFD office at all. The supervisor would open the door, gesture outside, and tell him to find somewhere else to sleep and to return in the morning to see if a placement had opened up.

In late 2019, CYFD placed Jacob with a foster family who moved to Arizona. While in Arizona, Jacob did not have a single visit from his assigned CYFD PPW. Jacob left this placement in August 2020 and came back to Albuquerque to again stay at the CYFD office

building. CYFD thereafter placed Jacob with a foster family who left him by himself without any running electricity or food for two weeks. Jacob's final placement was a guardianship arrangement that started in May 2021. At the age of 17—only one year before he would age out of CYFD custody— Jacob was finally placed in a home that met his needs. Jacob aged out of foster care in May 2022.

Several times throughout [Jacob's nearly 6 years in state custody](#), CYFD fell considerably short of their obligations under New Mexico law. CYFD further [violated its duties and responsibilities](#) to ensure a safe placement for Jacob under the Department's internal policies and the Foster Child and Youth Bill of Rights. These violations by CYFD are not merely technical oversights—they had a direct and negative impact on Jacob's safety, emotional development, and ability to form lasting bonds. Jacob made clear to the NMDNJ: all he wanted was a loving home. CYFD not only failed to give him that, they left him with deep, lasting trauma.

2. Case Study: "Emma G."

Emma G. entered CYFD custody at the age of seven in February 2014. Both of her parents were incarcerated, and Emma was taken in by her maternal grandmother, Eleanor R. Emma was ultimately removed from Eleanor's home after Eleanor physically abused her, used heroin, and threatened suicide during a mental-health crisis.

Emma came into CYFD's custody with multiple mental health and behavioral health diagnoses, including Post-Traumatic Stress Disorder, Mood Disorder, Unspecified Anxiety Disorder, and Social Interactive Disorder. As a result, Emma understandably needed a high level of care. CYFD failed to meet her needs. Instead, the Department placed Emma on an assembly line of residential treatment centers, in-patient behavioral health units at hospitals, treatment foster care settings, and ultimately a CYFD office building. Each placement subjected Emma to distinct forms of physical and emotional trauma.

The NMDNJ interviewed Emma in June 2025. Emma described CYFD PPWs placing her in multiple congregate care and in-patient facilities during her first five years in CYFD custody. Emma stated that anytime her behaviors became too difficult to manage for a foster parent or for CYFD, they would effectively warehouse her in an out-of-state facility for several months. During Emma's first five years in CYFD custody, CYFD placed Emma at four separate congregate care facilities for a total of 40 months.

Emma was placed at Desert Hills Residential Treatment Center in 2016 when she was nine years old. Emma reported watching a girl around her age commit suicide in front of her. She recalled Desert Hills employees carrying the deceased child's body out in front of the rest of the residents. After leaving Desert Hills in November 2016, CYFD placed Emma in a

behavioral health hospital in El Paso, followed by a treatment center in San Marcos. She then spent a brief period in treatment foster care at Presbyterian Hospital before being transferred to another facility in Austin in March 2018. In October 2019, she was released to her third stint in treatment foster care in New Mexico.

Emma reported several adverse experiences while staying in congregate care. Emma recalled one staffer at a facility calling her a “good for nothing bitch” and using violent and hostile physical restraints against her and fellow youth. One time, Emma stated that a facility staffer squeezed her so hard that the blood vessels in her face would pop, creating bruising that resembled freckles. Emma also discussed instances where staff would lock her in a room with cement walls covered in blood, inject her with medication to stabilize her, and turn off the lights until the medication took effect.

After Emma was discharged from these treatment facilities, CYFD began a pattern of placing her with foster parents who had never cared for teenagers and were incapable of meeting her required level of care. In April 2021, CYFD placed Emma with a pastor and his wife. CYFD failed to educate these foster parents on Emma’s mental health diagnoses and how to properly respond to her behavioral challenges. Emma’s placement with the pastor lasted less than a month. In a four-week span, CYFD placed Emma in four different behavioral health hospitals in Albuquerque and Las Cruces while it tried to find a stable placement.

In June 2021, CYFD placed Emma in treatment foster care for another 12 months. Upon discharge from that placement in June 2022, CYFD again paired Emma with foster parents without appropriately considering whether they had the training and resources to address Emma’s behavioral needs. In September 2022, CYFD placed Emma with a neighbor of one of her classmates. In a report provided to the Children’s Court in November 2022, a CASA aptly noted what should have been clear to CYFD—that “there is a pattern of misplacement in regular foster care homes since Emma’s discharges from TFC [treatment foster care] in April 2021 and June 2022. Emma requires a higher level of care of placement due to her behaviors.”

In March 2023, CYFD placed Emma with her maternal aunt and uncle, Claire C. and George R., who already had legal guardianship of her infant baby sister. At the time of the placement, CYFD was aware, or should have been aware, that George had been convicted of several serious criminal offenses including burglary, aggravated battery against a household member, violation of a restraining order, interference with communications, and possession of a controlled substance. CYFD should have considered his criminal history in determining suitability for resource family licensure. George’s prior convictions indicated the

potential for violence, disregard for court orders, and a propensity for narcotics use. CYFD ignored each of those red flags.

Shortly after Emma was placed with them, George was criminally charged by the Rio Arriba County Sheriff's Department for drug trafficking and contributing to the delinquency of a minor. The Criminal Complaint alleged that (1) George and Claire forced a 15-year-old living in the home to sell drugs to students at Española Valley High School, (2) Claire brandished a firearm at the 15-year-old, (3) George would count fentanyl pills and consume narcotics in the presence of the children, (4) Emma's 10-month-old sister had access to fentanyl in the home, and (5) George and Claire offered Emma fentanyl, and allowed another 10-year-old minor in the home to smoke marijuana. According to an Affidavit for an Arrest Warrant filed on July 26, 2023, CYFD had investigated and determined that allegations of wrongdoing by George and Claire could not be substantiated:

Affiant continued this investigation on July 13th, 2023, at 1109hrs, Affiant contacted the C.Y.F.D. case agent [REDACTED] by telephone, who was assigned the case of [REDACTED]. During Affiant's conversation with the C.Y.F.D. investigator [REDACTED] provided Affiant copies of the original C.P.S. reports by email. Also, during the recorded telephone interview, Affiant was advised by the C.Y.F.D. caseworker that both incidents had been investigated by their agency, and she did not observe any signs that would suggest the reported allegations were substantiated. Additionally, Affiant was informed that the Rio Arriba County Sheriff's Department assisted her in the investigation on July 6th, 2023, where [REDACTED] was arrested on unrelated charges to this incident; on further investigation, Affiant is aware that Sgt. Gurule arrested [REDACTED] due to a Misdemeanor warrant.

Despite detailed allegations uncovered during law enforcement's investigation—and a Criminal Court's determination that there was probable cause for George's arrest—CYFD continued to explain away and make excuses for the risk that Emma, her infant sister, and other children in the home still faced. An August 14, 2023, permanency report authored by CYFD and submitted to the Children's Court contains the following provision:

19. Other pertinent information:

[REDACTED] stated she is happy to be living with her family and younger sister. The Department has seen a significant improvement in behaviors. However, [REDACTED] is having difficulties in the home due to the extended family members making several reports on the home. These reports are being made with CYFD and law enforcement which have had several different outcomes. Some that include, local law enforcement removing the children from the home, numerous SCI reports for several different accusations on caretakers in the home. Criminal accusations which have resulted in the arrest of her uncle and aunt being required to live out of the home. Thus far, all accusations have been determined to be false and are made out of retaliation by extended family members. However, the repeated encounters with law enforcement have caused a disruption in this families daily living and understandably frustrations.

After George's arrest, Emma continued to live with Claire and the three other minors. In late August 2023, Claire and her 15-year-old daughter physically attacked Emma after a disagreement. Emma subsequently described the attack and the injuries she suffered, which included a burst eardrum that triggered an ongoing seizure disorder.

After the incident, and due to her physical injuries, CYFD removed Emma from Claire’s custody. The Department’s actions were too late—Emma’s harm could have been avoided if it timely acknowledged that Emma’s aunt and uncle were poorly suited to meet her physical and emotional needs.

Notably, CYFD was sanctioned by a Children’s Court Judge for failing to ensure Emma’s well-being when placing her with George and Claire. Per a Special Master report that was later adopted by the Children’s Court judge, CYFD committed the following violations in Emma’s case:

- Failure to provide George and Claire with specialized training for Emma’s behaviors after being ordered to do so on June 12, 2023;
- Failure to conduct individualized placement meetings for Emma, after being ordered to do so on April 24, July 17, and August 24, 2023;
- Failure to identify and provide educational programs for Emma after being ordered to do so on June 12, and July 17, 2023;
- Failure to provide Emma with individual therapy after being ordered to do so on June 12 and August 28, 2023; and
- Failure to create and provide a mental health plan for Emma, after being ordered to do so on June 12, 2023.

Unfortunately, CYFD continued to fail Emma after removing her from George and Claire’s custody. Emma was forced to stay at the CYFD office building in Albuquerque from late August 2023 until October 2023. While there, Emma reported being primarily served reheated frozen food that was meant for minors at the juvenile detention center. This was in clear violation of her right under the New Mexico Foster Care Bill of Rights to receive adequate and healthy food.



Figure 23. Photo of meal, intended for juvenile detention youth, regularly served to Emma during her two-month stay in the CYFD office.

Emma reported that CYFD staff and security guards verbally assaulted and physically abused her. One CYFD security guard told Emma she needed “a good old-fashioned ass whooping,” while another security guard pushed her to the floor to restrain her. CYFD staff even refused to give Emma pain medication while she was recovering from the eardrum rupture suffered just months earlier. While

staying at the CYFD office, Emma had no privacy. Many of her conversations, including confidential discussions with her GAL and youth attorney, were recorded. She was even monitored while showering and grooming.

In October 2023 at age 16, given all that she endured for nearly ten years in state custody, Emma ran away from New Mexico. Emma went to Atlanta, Georgia, where she lived with her boyfriend and his family. As her legal custodian, CYFD remained obligated to ensure that Emma's medical and educational needs were met. Yet CYFD refused to work with Emma and her youth attorney in obtaining a referral to an ear, nose, and throat specialist for the injuries she sustained just two months prior. CYFD also refused to give Emma any financial support, assess her environment at her new placement, or provide her with her birth certificate, social security card, and other identifying documents.

CYFD was again sanctioned by the Children's Court for their blatant failure to meet Emma's needs. The Court ordered CYFD to ship Emma's personal belongings to her in Georgia. CYFD initially refused and then delayed shipping the items under the guise of needing an "endorsed" court order. When CYFD finally shipped items to Emma, they sent the [wrong items](#) that were either donated or belonged to another child. Emma received travel size toothpaste, clothes, a single shoe, and another child's personal photos and belongings. The Children's Court sanctioned CYFD and required the Department to reimburse Emma for the value of the items CYFD lost. CYFD's failure to return Emma's personal belongings to her was a violation of Emma's right under the Foster Child and Youth Bill of Rights to have her personal effects secured and transported to her. Beyond that, it was deeply demoralizing for Emma—a painful reminder that CYFD wasn't just neglecting her needs, but showing her she didn't matter.

Emma stayed in Georgia from October 2023 until she aged out of CYFD custody in February 2025. Throughout [Emma's more than 20 placements](#) over an 11-year period, CYFD frequently [violated New Mexico law](#), internal policies and protocols, and the Foster Child and Youth Bill of Rights. Emma's transition into adulthood is characterized by overcoming—rather than benefiting from—CYFD's involvement in her life.

3. Case Study: "Aliyah M."

On May 16, 2025, Aliyah M.—a pregnant 17-year-old young woman in CYFD's legal custody—took her own life in Springer, NM.³¹¹ Aliyah was found with pills next to her bed, a "goodbye" letter written to her ex-boyfriend, and the words "do not try to save me do not

³¹¹ This marked the second time in just over a month that a teenager in CYFD's custody took their own life, after Joshua H. died by suicide at AMIKids in Albuquerque.

resuscitate” written on her left forearm in ink. An [OMI autopsy](#) concluded that Aliyah’s death was caused by toxic levels of Benadryl.

Between her birth and 2011, CYFD investigated multiple reports of abuse and neglect involving Aliyah’s biological family. Originally from southeastern New Mexico, Aliyah was adopted in 2013, and by 2023, her adoptive family voluntarily relinquished their parental rights. In the months before her death, Aliyah was one of many teenagers in CYFD custody who experienced harmful, nomadic placement patterns. She “couch surfed” for extended periods of time, was frequently listed as a runaway, resided in youth shelters, and stayed in a CYFD office building several times. Aliyah was also known to stay with her ex-boyfriend at his mother’s house.

As of March 2025, Aliyah had been reported as a missing person.³¹² On [March 7, 2025](#), APD officers located Aliyah at Hope House, an all-female shelter in Albuquerque. CYFD confirmed to law enforcement that Aliyah was in its custody, but noted “they had her staying with a foster parent, but it may not have been updated to reflect that she was at [Hope House] because it sometimes takes a few weeks.” Either CYFD failed to document Aliyah’s placement and lost track of her whereabouts or were relying on a case management system so outdated that it takes “weeks” to update information that modern systems can process in seconds. Either possibility is deeply troubling. Aliyah told an APD officer that her own CYFD caseworker drove her to Albuquerque—raising serious questions about how the Department could lose track of her location. APD’s report noted:

Upon arrival, of the residence I made contact with a staff member of Youth Development Inc (YDI) who informed me the home is actually shelter/housing for juveniles of the state that can't be placed with a foster parent yet. I spoke with [REDACTED] who was in good health and did not know she was reported missing. [REDACTED] told me her CYFD case worker [REDACTED] actually drove her to Albuquerque and has been a child in state custody for a while. [REDACTED] said she believed her ex-boyfriend or his family might have reported her missing because she never told them she was leaving.

I attempted to contact [REDACTED] and her supervisor [REDACTED] but got no answer. I contact CYFD and they informed me [REDACTED] was in state custody and they had her staying with a foster parent but it may have not been updated to reflect she was at [REDACTED] because it sometimes takes few weeks. The CYFD operator confirmed they do work YDI.

On March 9, 2025, APD returned to Hope House in response to a disturbance involving Aliyah. APD reported that Aliyah had become aggressive during a verbal altercation with other residents³¹³ and was threatening to harm herself and others. CYFD was notified of the incident. Due to her escalating behavior and threats, Aliyah was transported to Presbyterian Kaseman Hospital for a mental health evaluation.

³¹² Aliyah believed the missing person report was made by her ex-boyfriend or his family, as she had previously stayed with them and did not tell them she was leaving.

³¹³ One of the residents involved in the dispute was just 13 years old. Placing minors of vastly different ages and maturity levels in the same house together highlights the lack of individualized care and risks and instability often associated with congregate care settings.

By April 24, 2025, Aliyah’s managed care organization (MCO) care coordinator noted that Aliyah had returned to stay in the CYFD office. Shortly after that, Aliyah was transported to Springer, New Mexico—over five hours away from the only semblance of a support system she had in Hobbs—to be placed with a new foster parent.³¹⁴

CYFD failed to get Aliyah the help she needed in a timely manner. CYFD was aware that Aliyah was on medication for depression and had been required to undergo a psychological evaluation in early March after making threats to harm herself and others. It was not until May 2, 2025—nearly two months after her threats of self-harm—that Aliyah’s CYFD PPW requested assistance from her MCO care coordinator in locating mental or behavioral health providers. While the care coordinator provided some options, case notes are unclear if the PPW ever followed up or secured those resources prior to Aliyah taking her life. Due to bureaucratic malaise, excessive workloads, or other systemic breakdowns, CYFD did not act with the urgency necessary to address the mental health issues that contributed to Aliyah’s suicide.

Experts agree that CYFD did not provide Aliyah the safety, stability, and support she needed. A fatality review of Aliyah’s case conducted by the *Kevin S. Co-Neutrals*³¹⁵ outlined CYFD’s shortcomings. The Co-Neutrals noted that Aliyah “demonstrated resilience, sought help from CYFD when in crisis, and frequently showed a desire for connection to supportive adults and stability during [her] time in custody.” The Co-Neutrals found that: (1) Aliyah was not placed in a stable family-based setting with adequate support, (2) placement planning processes were often untimely, uncoordinated, scattershot, and inappropriately restrictive, (3) CYFD PPWs changed frequently, hindering efforts to coordinate with clinical providers, and (4) therapeutic and supportive services were not consistently provided. Even CYFD’s actions after Aliyah’s death were deficient. The Co-Neutrals explained:

“The administrative response to [Aliyah’s] death was fully inadequate, marked by incorrect information, poor inter-agency coordination and the slow exercise of post-fatality investigation and oversight. Symptomatic of this approach, CYFD often pledged to provide key information and reports to the Co-Neutrals, which typically did not arrive as promised, if at all.”

When children are removed from abusive or neglectful homes, the foster care system is intended to provide safe, family-based environments to promote healing. These case

³¹⁴ Aliyah’s last foster parent and the respite provider she was staying with on the date of her death were both CYFD employees.

³¹⁵ The *Kevin S.* fatality review also included Joshua H.’s case, discussed elsewhere in this report.

studies demonstrate the opposite. CYFD shuffled children through unsuitable placements without addressing their physical and behavioral needs, perpetuating the cycle of instability and deepening their trauma.

G. Systemic Failure: Unsafe & Traumatic Office Stays

Office buildings are not designed to meet the psychological or developmental needs of children. When children in CYFD custody are made to sleep in offices—often without privacy, routine, or satisfactory care—it disrupts their sense of safety and leaves lasting emotional harm. Under the *Kevin S.* settlement agreement, CYFD agreed to stop placing children in CYFD offices unless there were extraordinary circumstances necessary to protect the safety and security of the child.³¹⁶ This settlement requires CYFD caseworkers to request approval by a manager, deputy director, and/or Secretary to place children in an office setting. It also obligates CYFD to document efforts made to identify potential appropriate placements for the child and the extraordinary circumstances justifying the placement.

According to the *Kevin S. Co-Neutrals 2024* annual report, CYFD fell significantly short of its obligations under the settlement to limit office stays. Between 2022 and 2024 alone, the number of children who had been placed at a CYFD office doubled each year. [Excerpts from the 2024 Co-Neutrals' Report](#) showed that over a five-year period from 2019-2024, the number of children staying in CYFD offices rose nearly 500%. This explosion of children in offices took place despite a 22% reduction in the number of children in state custody.³¹⁷

Table 6. Children with any placement in a hotel/motel, out-of-state facility, or CYFD office (including Receiving Center), 2019-2024. Reproduced from *Kevin S. Co-Neutral 2024 Annual Report*.

Category	2019 (N = 3,881)		2020 (N = 3,344)		2021 (N = 2,949)		2022 (N = 2,755)		2023 (N = 2,944)		2024 (N = 3,026)	
	#	%	#	%	#	%	#	%	#	%	#	%
Children with any placement in applicable setting ¹⁰⁸	83	2%	63	2%	102	4%	82	3%	199	7%	412	14%
<i>Children with placement to any applicable setting, by type of setting</i>												
Out-of-state facility	57	1%	31	<1%	27	<1%	14	<1%	18	<1%	32	1%
Office (including Receiving Center)	34	<1%	32	<1%	85	3%	71	3%	185	6%	404	13%
Hotel/motel	0	0%	2	<1%	3	<1%	6	<1%	0	0%	0	0%

³¹⁶ *Kevin S. Settlement Agreement* at 5a (Appendix B, Target Outcome No. 1).

³¹⁷ *Kevin S. 2024 Co-Neutrals' Annual Report* at 58.

The Co-Neutrals found that over half of the office placements occurred at the Receiving Center or the office building in Bernalillo County. They further noted that:

“[N]one (0%) of the 708 office placements reviewed by the Co-Neutral team documented that the placement was made due to extraordinary circumstances necessary to protect the safety and security of the child and with approval by the Secretary or PSD Director prior to placement, as required by [the final settlement agreement].”³¹⁸

CYFD repeatedly overlooked the quality of life for children staying at its offices, a fact made plain by photographs provided to KOB 4 showing the inadequate conditions inside its Albuquerque buildings. Some children were given mattresses or cots, while others appeared to be sleeping on the floor. Children did not have separate living spaces and were without dedicated areas to place toiletries or personal belongings. One former permanency supervisor told the NMDOJ that makeshift bedrooms at CYFD’s Albuquerque office were “nasty” and “awful,” citing visible food crumbs, dirty carpets, and general unsanitary conditions.



Figure 24. Photos of CYFD office facilities that have been used to house children in state custody. Originally released in Brittany Costello, [4 Investigates: CYFD office stays](#), KOB (February 20, 2025).

³¹⁸ *Id.* at 61.

CYFD staff reported that attempts to make the office environment humane were met with discipline. One permanency supervisor told the NMDOJ that staff were reprimanded after trying to provide a teenager in state custody with a mattress to sleep on. Because the youth had run away from an assigned placement to stay in the office, CYFD leadership insisted that office conditions remain uncomfortable in order to discourage office stays.

As office stays increased sharply in recent years, Secretary Casados repeatedly addressed the issue before the New Mexico Legislature, the *Kevin S.* arbitrator, and other stakeholders. To evaluate whether those representations reflected conditions on the ground, the NMDOJ reviewed CYFD's own data, law enforcement records, LFC proceedings, and transcripts from *Kevin S.* arbitration hearings. That review demonstrates that CYFD leadership consistently understated the number of children housed in Department offices and the Receiving Center, and minimized the disorder and instability of these environments.

CYFD OFFICE STAYS

WHAT CYFD SAYS ABOUT OFFICE STAYS ENVIRONMENT

- Secretary Teresa Casados from 6/11/24 LFC Hearing —“The receiving center is a very welcoming environment with staff 24/7”
- Secretary Teresa Casados from 9/17/24 LFC Hearing —“I can assure you the receiving center is an amazing environment for kids...”
- Deputy Secretary Valerie Sandoval from 11/13/24 Kevin S. Testimony—“The receiving center is a great place.”

WHAT THE OFFICE STAYS ENVIRONMENT AT CYFD REALLY LOOKS LIKE

- 7/9/24 Police Report— 10 year old tries to run into traffic and commit suicide during office stay at the receiving center. He tells police “What’s the point of living if I’m going to live here forever.”
- 9/28/24 Police Report—9 year old tells CYFD Staff “she wanted to die, she wanted to kill herself.” 9 year old tried to choke herself with cord from air mattress while staying at the receiving center.
- 10/10/24 Police Report –Police and CYFD workers find pipe used to smoke fentanyl in living space of CYFD office.
- 11/13/24 Police Report and SCI Report—CYFD Worker slaps 9 year old child when trying to de-escalate a situation at the receiving center.
- 1/4/25 Police Report— 14 year old female claims she was sexually assaulted by another male staying at CYFD office.
- 3/26/25 Police Report—10 year old staying at receiving center says that he wants to take security guard’s gun and kill himself.

WHAT CYFD SAYS ABOUT THE NUMBER OF CHILDREN STAYING IN OFFICE STAYS

- Secretary Teresa Casados from 6/11/24 LFC Hearing —“At this point in time, we have about 22 office stays on a regular basis.”
- Secretary Teresa Casados from 9/18/24 LFC Hearing —“I believe as of last night, we had 20 kids in offices.”
- Secretary Teresa Casados from 11/22/24 Kevin S Testimony—“We have been steady at about between 10 and 20 kids.”
- Secretary Teresa Casados from 12/11/24 LFC Hearing “Seventeen kids slept in offices at CYFD last night.”
- Secretary Teresa Casados from 6/25/25 LFC Hearing —“There are no more children having office stays in Bernalillo County.”

ACTUAL NUMBER OF KIDS STAYING AT CYFD OFFICES

- Kevin S. 2023-Co-Neutral Report—“The number of children with placements in offices more than doubled from 2022-2023”
- FACTS 2023 and 2024 Data—CYFD had 57 kids staying in offices and at the receiving center in June 2024.
- FACTS 2023 and 2024 Data—CYFD had 59 kids staying in offices and at the receiving center in September 2024.
- FACTS 2023 and 2024 DATA—CYFD had 40 kids staying in offices and at the receiving center in December 2024.
- 6/25/25 Police Report—CYFD calls police to report a 17 year old missing after he was staying at the CYFD Office Building and ran away.

Figure 25. Comparison of CYFD’s representations about office stays and office conditions to CYFD FACTS data (2023–2024), law enforcement calls for service, and Kevin S. arbitration testimony. FACTS data included in Brittany Costello, [4 Investigates: CYFD office stays](#), KOB (February 20, 2025).

On June 25, 2025, Secretary Casados represented to the LFC that “there are no more children having office stays in Bernalillo County.” At the very same time Secretary Casados made this assurance, [NMSP responded](#) to a runaway report involving a 17-year-old “staying at the CYFD building” in Albuquerque.³¹⁹ There were still clearly children staying in CYFD offices in Bernalillo County.

While the number of children staying at CYFD offices in Albuquerque was decreasing during this time, witnesses informed the NMDOJ that this decline was misleading. CYFD had been transporting youth to other offices around the state, rather than genuinely moving away from the practice of housing children in office buildings.³²⁰

CYFD leadership has previously touted one of its sites, the Receiving Center, as a more nurturing environment for those children 12 and under.³²¹ Yet law enforcement records indicate that children of *all ages* frequently interact in CYFD’s facilities. For example, in a police [lapel video from March 22, 2024](#), at least five children of different age groups and sexes assemble in the office building hallway. In that footage, a younger child stands close to a teenager who is heard shouting and cursing about firearms and being in jail. This contrast underscores how inappropriate and developmentally damaging such an environment can be.

The NMDOJ analyzed over 130 reports documenting NMSP and APD investigations into incidents that occurred at the CYFD main office building in Albuquerque. This review demonstrated that law enforcement is routinely dispatched to the CYFD offices to address a host of issues, including sexual assaults, missing persons, threats of suicide, physical altercations between staff and children, and drug possession.

Reports of sexual abuse represent some of the most serious incidents involving children residing in the Albuquerque CYFD office. In one example from December 2022, a 10-year-old child staying in the office reported that a 14-year-old child put his penis in the younger child’s buttocks. CYFD staff can be heard detailing the sexual assault allegations to APD in a [lapel video](#). In December of 2024, a [14-year-old female reported to NMSP](#) that a 15-year-old male cornered her in a room, shut the door, and grabbed her from behind and

³¹⁹ NMSP responded to another call at the CYFD office building in Albuquerque two days earlier after a child injured two security guards by kicking, punching, and threatening them with a pen.

³²⁰ In the same June 2025 LFC hearing, Secretary Casados recognized that there were at least six counties that still have kids in the office.

³²¹ In the June 11, 2024, and September 17, 2024, LFC hearings, and to the *Kevin S.* arbitrator on November 13, 2024, former Secretary Casados and Acting Secretary Valerie Sandoval described the Receiving Center as “very welcoming,” “an amazing environment” and “a great place.” Secretary Casados clarified to legislators at the June 25, 2025, LFC hearing that teenagers and other youth were separated, as the Receiving Center only allows those up to age 12.

fondled her breasts. A CYFD employee told NMSP that the same male juvenile also fondled the employee's breasts from behind just two days earlier. This employee acknowledged to NMSP that she was watching the male juvenile to prevent him from sexually assaulting other youth. NMSP's report shows that CYFD employees were aware of the male's sexualized misbehavior yet failed to take reasonable and necessary precautions to separate members of the opposite sex and prevent further assaults.

Less than a month later, [another sexual assault was reported](#) at the CYFD offices in Albuquerque. A 14-year-old female reported to law enforcement that a 13-year-old male went into her bedroom, grabbed her by the throat, and placed his penis in her vagina:

before [REDACTED] entered the room. She advised he then got on the bed on top of her and had her by the throat again. She advised he pulled her clothes down and began to touch her vaginal area with his hands before entering with his penis. [REDACTED] stated she believed [REDACTED] ejaculated inside of her. [REDACTED] was advised she did not have to disclose any more information, she was advised an interview with a professional person who was not a law enforcement officer would speak to her.

Other portions of the police report show that CYFD staff who were supposed to be supervising youth were unaware of how to monitor children to prevent these types of sexual assaults. A CYFD employee told NMSP that "he was unsure of any policies in place that required him to check on juveniles throughout the night":

in room 179B identified as the room [REDACTED] sleeps in. [REDACTED] stated both juveniles were in the bed fully clothed from what he could see, he advised he had not heard any noises coming from the room before entry. [REDACTED] stated he was unsure of any policies in place that required him to check on the juveniles throughout the night. [REDACTED] stated when they found the juveniles he yelled at [REDACTED] to exit the room and go to his own.

APD and NMSP investigations also routinely document instances of children living in CYFD offices attempting self-harm and suicide. A report from January 25, 2024, notes that a 17-year-old tried to jump off the second story at the Albuquerque CYFD office after CYFD staff would not allow her to go into the kitchen area:

At this point, I made contact with the female, who was identified as [REDACTED]. I began speaking with her about the incident before my arrival. She told me she got upset because CYFD staff would not open the kitchen so she could grab a jug of water. She said that upset her and escalated her to yell at the top of her lungs. She then stated she walked upstairs, placed her feet over the ledge, and wanted to jump to hurt herself. She did inform me that she was not suicidal but did want to hurt herself. The on-duty security guard was able to grab her successfully, lay her on the ground, and eventually escorted her downstairs until we arrived.

Unfortunately, threats of self-harm are not isolated incidents at CYFD offices. In September 2024, NMSP were called to the CYFD office regarding a 10-year-old female who had attempted suicide. A [security guard described](#) his efforts to stabilize the girl, and a [CYFD employee further explained](#) how the child intended to take her life. In another instance, an APD [lapel video](#) from July 9, 2024, shows a clearly resigned 10-year-old male telling an officer "what's the point of living if I'm going to live here forever?"

Former Deputy Director of Permanency Serna explained how a lack of support and training for CYFD staff made it difficult to prevent and respond to incidents of self-harm. Serna recalled that staff were not trained on proper de-escalation techniques, which was problematic given the pronounced behavioral health issues experienced by many youth in

the child welfare system. At best, staff were unprepared to serve as supportive and caring guardians for children staying at the office. At worst, CYFD employees and affiliates were accused of either ignoring dangerous behavior by youth in offices, or actively provoking it through verbal harassment and physical force.

In an [NMSP police report](#) dated May 1, 2024, law enforcement detailed how a 10-year-old female ran outside of the CYFD offices and onto Indian School Road. A CYFD security guard called police and explained how the child was almost hit by two vehicles, further noting that he felt the child was not safe in CYFD custody. The investigating NMSP officer reprimanded CYFD's staff, telling her she needed to do more to ensure the safety of children staying in the CYFD office:

the reality [REDACTED] could have gotten hit by a vehicle in the roadway. I questioned [REDACTED] about CYFDs no touch policy in relation to if a child is in imminent danger or capable of endangering him or herself. I had a conversation with [REDACTED] about allowing a 10-year-old girl exit the CYFD and doing nothing about it except call police. I expressed to [REDACTED] my deep concern for [REDACTED] safety in their custody and demanded assertion that if [REDACTED] attempted to exit the CYFD building again, she would be physically stopped and prevented from possibly crossing the roadway and being hit by a vehicle. [REDACTED] advised me she would stop [REDACTED] if she attempted to exit the building again.

Other CYFD offices demonstrated similar indifference to the behavior of youth in their care. In Roswell, law enforcement reported that staff simply gave children staying in their office a curfew and let them roam during the day—despite repeated reports of those children skipping school, drinking, using marijuana, and getting into trouble in the community. Officers described CYFD's approach as apathetic, stating that it felt like the Department had “thrown up the white flag.”

In another case, an NMSP report from March 25, 2024, states that CYFD staff were antagonizing a 17-year-old staying at the office. A security guard on duty informed police that CYFD employees were provoking the child for 4½ hours throughout the day, describing the child as “a headache who did nothing but give CYFD problems,” and a “pain in the ass.” The security guard told police that he had witnessed CYFD personnel exhibiting this same unprofessional behavior toward other youth in the office. The officer described the encounter in his police report:

I photographed the three broken windows, then proceeded to talk with the security guard who was on scene during this incident. I asked him if he knew what happened today with [REDACTED]. The security guard advised me that [REDACTED] had been stressed out since she had got there today which was about 2:30 PM to his recollection and the CYFD staff had not helped. He stated since he has been there all of them (referring to the CYFD staff) had been giving her shit. He stated up until he got the notification [REDACTED] was breaking windows, all CYFD staff had been doing is following and berating the girl [REDACTED]. I asked the security guard if he could specify what was being said by CYFD staff. He gave an example of a high school clique of people getting together and talking badly about someone while that person being talked about can hear what the others are saying. He then stated they were continuously doing that to [REDACTED] within 10-15 feet of her and being that he's a security guard he has no say in anything. I asked him if he had heard anything specifically said by CYFD staff regarding them berating her and making the situation worse. He stated it was more of them throwing jabs reminding her she's almost 18 years of age telling her she could do whatever she wants, stating “she's a headache, she's giving us problems, she's a pain in the ass” all within distance of [REDACTED]. The security guard stated [REDACTED] had been dealing with that for about 4 and a half hours prior to our arrival. I then asked if security had witnessed CYFD staff members doing this to other juveniles. He stated he had never witnessed staff members group up on a juvenile like he had witnessed today but stated it does happen on an ongoing basis from the entire staff saying certain things to other juveniles. He stated that [REDACTED] had barely arrived to CYFD around 6:00 PM so she wasn't involved in that with the other CYFD staff that she had unfortunately caught the tail end of it before [REDACTED] had enough of it.

A CPS Intake report from November 6, 2024, accused a CYFD-contracted behavioral health provider of slapping an eight-year-old child in the face at the Receiving Center. A CYFD employee who observed the incident reported the abuse through SCI. The reporting party noted the clinician slapped the child so hard the slap could be heard from down the hall. CYFD “screened-out” the report, determining that the Department did not have the authority to investigate an incident that occurred at a “crisis shelter” when the offender was not a “parent, guardian, [or] custodian.” This determination is curious for two reasons. First, it is telling that CYFD characterizes the Receiving Center a “crisis shelter” when doing so allows it to sidestep investigative responsibility, yet describes it as an positive environment when useful for a public relations purpose. Second, the policy produces an untenable contradiction by preventing CYFD—the child’s legal and physical custodian—from remedying misconduct by a provider inside CYFD’s own facility.

As part of its investigation, the NMDOJ spoke with multiple former CYFD employees who had been responsible for supervising children in office settings. These employees emphasized the difficulty in performing daily administrative tasks while simultaneously monitoring children living in their workplace. One former county office manager stressed that CYFD employees lacked proper training to care for these youth, and children staying in offices rarely received essential medical, therapeutic, or behavioral services or support.

Historically, the strain on staff in Albuquerque’s main CYFD office has been particularly acute. The NMDOJ interviewed Evan Sena, who previously worked as a PPW in CYFD’s Metro Region from January to November 2024. Sena explained that PPWs in his office were often forced to work their regular 8:00 am to 5:00 pm shift and then stay for a second overnight shift to supervise youth staying in the CYFD office or the Receiving Center. Sena stated that this practice resulted in some employees working for twenty-four hours straight. Mr. Sena further recalled that no medical staff or pharmacist was available on-site or easily accessible on call. This proved especially concerning because untrained staff were expected to dispense medication to children with complex, individualized needs.

Sena [described office settings](#) as “third world” and further explained that:

“It was one of the hardest jobs I think I’ve ever had, and I was in the Navy. And it was harder than the Navy. The amount of hours that they pushed on us and everything was so intense, and the amount of just chaos. I’ve never been in such a chaotic environment.”

Sena further described instances where CYFD employees were victims of verbal abuse and physical attacks from children staying at CYFD offices:

“Oh, I mean, I got beat up twice in one day . . . we got beat up all the time. Punched, spit at, bit, scratched, everything. Like it was a madhouse. It was horrible stuff. Our desks, the kids would go upstairs, grab our stuff on our desk and throw it everywhere. And then they would sometimes break into the top floor and then retaliate [against] whatever social worker pissed them off that day. . . . If the kids respected you, they left you alone. But if they did not respect you, or if you were mean to them, man they would call you everything.”

Sena’s account was similar to other employees who experienced assaults. On [October 7, 2024](#), NMSP responded to an incident in which a 13-year-old female battered two CYFD employees and a security guard. The youth charged at one CYFD supervisor and punched another in the face when they tried to intervene. The child grabbed a pair of scissors and attempted to cut herself. Another former PPW described an episode in which a child at the office broke a county manager’s tooth during a violent altercation. This same PPW recalled that when youth were transported from Albuquerque to the Los Lunas office, young female staff regularly feared for their safety.³²² Older teens housed there would often climb onto the building, kick walls, and threaten employees.

Beyond conflicts involving employees, CYFD has been incapable of preventing physical violence between youth staying in offices. On [June 23, 2024](#), NMSP was dispatched to a call at CYFD’s Albuquerque office that a 15-year-old ran into a 13-year-old’s “room” and began striking her. While attempting to flee from a security guard, the 15-year-old was nearly struck by two vehicles after running into oncoming traffic. Another incident was reported on [December 14, 2024](#), involving an 11-year-old diagnosed with PTSD, ADHD, and RAD.³²³ The child became irate, screamed at CYFD staff, and threw an object at another youth. CYFD’s employee on duty admitted to NMSP that he had failed to give the 11-year-old necessary medication to stabilize her mood.

Another inherent risk of using CYFD offices as revolving temporary placements is that staff struggle to effectively identify and prevent youth from bringing in contraband. For example, on October 10, 2024, NMSP was dispatched regarding a 13-year-old staying at the Albuquerque office who was found with a metal pipe that she stated was used to smoke “blues,” a street name for fentanyl. The potential presence of dangerous narcotics adds another layer of risk to an environment already marked by volatility and unpredictability for both youth and staff.

³²² This employee recalled children moving from Albuquerque to the Los Lunas office after the death of Joshua H. (discussed elsewhere in this report) to reduce media scrutiny.

³²³ PTSD – Post-Traumatic Stress Disorder; ADHD – Attention Deficit Hyperactivity Disorder; RAD – Reactive Attachment Disorder.

The turbulent conditions in CYFD offices are not unique to Bernalillo County. One former PSD employee who worked in southwest New Mexico stated that she would frequently sleep in her office overnight to monitor children residing there. She recalls turning the conference room and storage rooms into sleeping quarters for children. She explained that while employees try and stay awake, this was not always realistic after an eight-hour shift. She recalled feeling pressure from her supervisors to characterize unsafe conditions in the child's biological home as manageable in order to move children out of the office. The NMDOJ also spoke with a former facilities supervisor with the Early Childhood Education and Care Department (ECECD) with knowledge of CYFD's office stay practices. He noted that the ECECD building was attached to a CYFD building in Roswell and recalled another tenant-sharing arrangement in Clovis. The former facilities supervisor described children climbing onto the roof and causing havoc, skipping school, and directing disruptive outbursts towards staff. The situation became so hectic that ECECD considered allowing their employees to work from home until the turmoil could be addressed.

As quickly as the NMDOJ could compile its findings related to the harms of office stays, more disturbances at CYFD office buildings were already occurring. On September 23, 2025, NMSP responded to a battery call where witnesses reported that a CYFD employee hit a 16-year-old female staying at the office. During a scuffle in the parking lot, the employee threw a punch which struck the child in the face. The child was transported to the hospital with minor injuries, and the employee was terminated and charged with aggravated battery.

The most recent data reported by the Kevin S. Co-Neutrals underscores the breadth and severity of critical incidents occurring in office and similar settings. Between August 18 and December 31, 2025, CYFD and HCA reported 201 critical incidents to the Co-Neutrals, and the Co-Neutrals independently validated an additional 163 incidents during that same period.³²⁴ Critical incidents as defined by parties to the *Kevin S.* litigation include:

- Any fatality;
- Any near fatality to mean when a child in state custody experiences a serious or critical condition while in state custody. Examples of serious or critical conditions include critical internal injury, threatened organ failure, severe shock, substantial risk of death as determined by a medical assessment and other conditions that require life-saving interventions or admission to intensive care;
- Any serious injury means injury that requires medical attention or hospitalization;
- Any suicide attempt;
- Any allegation of restraint/seclusion;
- Any change in licensure within any facility in which a child in state custody is placed; and
- Any 911 call for a child placed in hotels, motels, offices, out-of-state or in congregate care. Congregate care includes a wide array of out-of-home settings including, but not limited to, residential treatment centers, shelters, group homes, crisis shelters, multi service homes, room and board facilities, other residential shelter care facilities for children, and group short-term living accommodations.

³²⁴ January 30, 2026 *Kevin S.* Report, at 16; January 30, 2026 *Kevin S.* Report, [*Attachment D. Additional Analysis of Critical Incidents*](#), at 1.

Of the 201 critical incidents identified by CYFD and HCA, the majority occurred in CYFD offices (124 incidents, or 62%).³²⁵ Further, approximately 80 percent of all office-based critical incidents during this period occurred in Bernalillo and Dona Ana counties.³²⁶

Settings of Critical Incidents

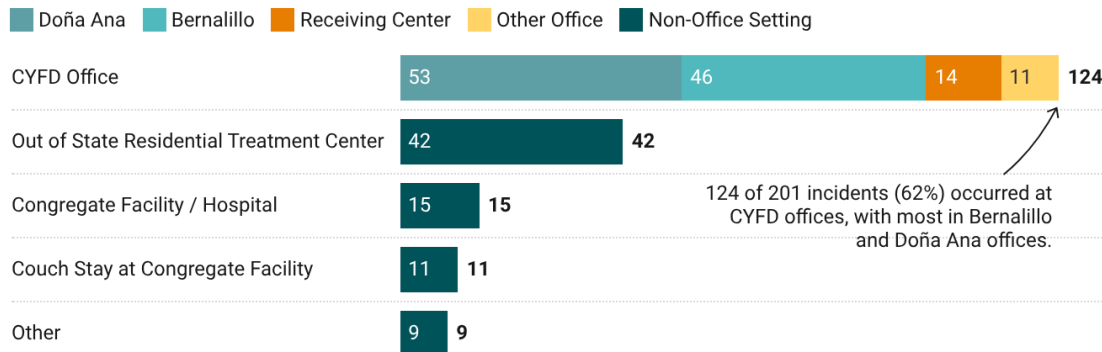


Figure 26. Critical incidents in CYFD offices and other settings, August 18-December 31, 2025. Reproduced from Attachment D, Additional Analysis of Critical Incidents, Kevin S. status report (January 30, 2026).

The majority of critical incidents occurring in CYFD offices were reported as calls to 911. These calls were made for a variety of reasons, including: child runaways; allegations of abuse, neglect, or serious injury; children harming peers or staff; dysregulated and aggressive children; property damage; sharing of inappropriate photos; transport for medical or mental health crises; and children being under the influence of substances.³²⁷ Co-Neutrals noted that “the predominant behavioral management tool staff use to manage children placed in CYFD offices remains to contact law enforcement.”³²⁸ Consistent with incidents identified by the NMDNJ, reports also highlighted “allegations of staff antagonizing children and escalating situations . . .”³²⁹

On January 19, 2026, Governor Lujan Grisham signed an [executive order](#) banning office stays beginning March 1, 2026, directing that “CYFD shall ensure that all children and youth in its care are placed in safe, appropriate, and licensed settings designed for care and supervision, including foster homes, kinship care, shelters, or transitional facilities.”³³⁰ It remains to be seen whether this order protects children, or merely protects against the public criticism consistently levied against the Department. To be sure, if real reform could be achieved through words alone, the entrenched practice of office stays would have been

³²⁵ Id.

³²⁶ January 30, 2026, Kevin S. Report, Attachment D. Additional Analysis of Critical Incidents, at 1-2.

³²⁷ Id. at 5.

³²⁸ Id.

³²⁹ Id.

³³⁰ Executive Order 2026-003, Ending the Practice of Children Staying Overnight in Children, Youth and Families Department Offices, (January 19, 2026).

addressed over five years ago through CYFD’s commitment in the *Kevin S.* final settlement agreement to end office stays by December 1, 2020.

Stakeholders remain uncertain whether this mandated change will resolve the problem or merely alter its form. CYFD reported to Co-Neutrals that most of the youth who had been placed in offices were being moved into alternative placements, including resource homes, congregate care and group home facilities, and a newly opened transitional facility in Las Cruces.³³¹ While expanding family-based placements is a welcomed development, shifting more children into congregate care facilities carries its own risks. New Mexico has already witnessed these risks firsthand—the NMDNJ’s investigation was prompted by the tragic suicide of a 16-year-old in one such facility.

While CYFD routinely cites the lack of available placement options as the reason children stay in offices, the Department must confront its own role in creating those conditions. CYFD bears primary responsibility for treating resource families with respect, supporting them so they remain in the system, and maintaining strong, continuous recruitment efforts.³³² Given the Department’s full awareness of the profound harm office stays inflict—and its capacity to remedy the placement shortages it cites—continuing this practice to any degree is no longer defensible.

When CYFD takes custody of a child, its mandate is to eliminate the harm that child is facing, not to create new harm in its place. Yet that is precisely what happens when children live and sleep in commercial office buildings. CYFD’s historical reliance on office stays deepens the trauma children already face and reinforces their sense of uncertainty and insecurity. As the *Kevin S.* Co-Neutrals make clear, “the State is unable to sufficiently remedy the many significant risks to child safety in the CYFD offices, and the practice of housing children in offices poses an immediate danger to children, youth, and staff.”³³³

H. Systemic Failure: Warehousing Youth in Congregate Care Facilities

Congregate care is an umbrella term for a wide array of out-of-home settings licensed to provide care for youth, including group homes, residential treatment facilities, emergency shelters, in-patient hospitals, and similar institutions.³³⁴ In New Mexico, many congregate

³³¹ January 30, 2026 *Kevin S.* Report, at 6, n. 9.

³³² See Section E. *supra*, “Devaluation of Foster Parents.”

³³³ January 30, 2026 *Kevin S.* Report, at 6.

³³⁴ US. Admin. for Children and Families, [A National Look at the Use of Congregate Care in Child Welfare](#) 1 (May 13, 2015, current as of June 2024).

care facilities operate as children's crisis shelters,³³⁵ community homes,³³⁶ and/or multi service homes.³³⁷

1. Stakeholders raise concerns about the effectiveness of congregate care.

a. Harms of congregate care and their impact in New Mexico.

While there is an appropriate, limited role for congregate care placements in the spectrum of foster care settings, "there is consensus across multiple stakeholders that most children and youth, but especially young children, are best served in a family setting."³³⁸ Stays in congregate care should be based on specialized behavioral and mental health needs of children, and for a short duration. Long-term group and institutional placements often cause youth significant developmental harm, and cost up to 10 times more than family-based placements.³³⁹ Further, youth with a background in group placements: (1) are almost 2.5 times more likely than their peers in foster care to become delinquent, (2) have worse educational outcomes than youth in family foster care, including being less likely to graduate high school, (3) are at risk of physical abuse, (4) lack opportunities to develop critical life skills and positive relationships, and (5) tend to experience these placements as prison-like, punitive, and traumatic.³⁴⁰ For all practical purposes, congregate care facilities are the modern institutional equivalent of orphanages.

Dr. George Davis, an Albuquerque-based, board certified child and adolescent psychiatrist, provided further insight into the flaws of the congregate care model. Dr. Davis explained that when operating a group program with multiple children, the rules have to be standardized. A "one size fit all" approach often deprives youth of the kind of diversity or specialization of treatment necessary to address individual needs.³⁴¹ In speaking with the NMDNJ, Dr. Davis outlined recurring issues with congregate care facilities, including inadequate facilities, misuse of psychotropic medications for sedations, lack of trauma-informed staff, lack of available therapeutic programming, and standardized rules-based structures as opposed to a clinical focus on children. He expressed that these placements

³³⁵ 7.8.3.7(I) NMAC. A children's crisis shelter is a facility providing short-term (usually less than 90 days) emergency living accommodations to children in a crisis situation such as abuse, neglect, or runaway.

³³⁶ 7.8.3.7(L) NMAC. A community home is a facility that operates 24 hours a day providing full-time care, supervision and support to no more than 16 children in a single residential building.

³³⁷ 7.8.3.7(FF) NMAC. A multi-service home provides residential care to children referred by agencies or parents because of abuse, neglect, delinquency, substance abuse, or other problems.

³³⁸ US. Admin. for Children and Families, [A National Look at the Use of Congregate Care in Child Welfare I](#) ("Exec. Summary") (May 13, 2015, current as of June 2024)

³³⁹ Casey Family Programs, [Information Packet: Safe Children](#) 1 (June 2022).

³⁴⁰ *Id.* at 2 ("What are the outcomes for youth placed in group and institutional settings?").

³⁴¹ Trans. George Davis, 170:9-171:1 (Day 4 of Arbitration), *Kevin S. v. N.M. Children, Youth and Families Dep't.* (Nov. 12, 2024).

are the perfect opportunity for abuse and neglect to take place, and will never be an appropriate substitute for the firm attachments and regular brain development available in family settings.

New Mexico has experienced first-hand the consequences of relying too heavily on congregate care. Over the past 15 years, multiple facilities have been investigated for subjecting youth to physical and psychological harm, including:

- Bernalillo Academy—Closed in December 2021 after an investigation found widespread abuse, staff misconduct, and inadequate supervision. An earlier 2012 inquiry uncovered the extensive use of physical restraints;
- Peak Behavioral Health—An investigation by Disability Rights New Mexico revealed countless instances of resident-on-resident violence, attempts of suicide or self-harm, and incidents of resident elopement from the facility; and
- Desert Hills—Lost its operating license in 2019 after frequent assaults on staff by youth, peer-to-peer violence, and poor supervision.

b. Fiscal risks and policy misalignment in CYFD's use of congregate care.

Separate from these harms, the LFC also highlighted fiscal drawbacks of congregate care. A June 2025 LegisStat report noted that New Mexico has historically over-relied on congregate care, despite federal guidance limiting its use to short-term treatment for acute behavioral health needs. Medicaid only reimburses medically necessary stays in accredited residential treatment centers—not group homes—making such placements costly and misaligned with federal policy.³⁴² While the state Legislature appropriated \$20 million in 2022 to expand community-based behavioral health resources, CYFD proposed using part of that appropriation for congregate care group homes, risking violations of *Kevin S.* requirements and a loss of federal funding. Despite LFC warnings, CYFD authorized the operation of two congregate care facilities—AMIKids and Hope House—in FY 2025.

In 2022, the Legislature appropriated \$20 million for start-up costs for behavioral health providers to establish evidence-based services that would be eligible for Medicaid or federal Title IV-E funding. For two years, these funds went unspent and were reauthorized for FY25. This appropriation aimed to address insufficient numbers of behavioral health providers able to serve children with complex needs and deliver services eligible for federal reimbursement.

CYFD spent less than \$5 million of the \$20 million appropriation for purposes aligned to the appropriation's intent (start-up costs for behavioral health services), though it unclear if the contracted services CYFD authorized will be Medicaid or Title IV-E eligible.

CYFD has spent over \$2.8 million of the \$20 million behavioral health appropriation on congregate care group homes, with contracts to AMI Kids and YDI. These facilities are not eligible for Medicaid or Title IV-E.

The department spent the rest of the appropriation on a variety of department activities and initiatives, including family resource centers and other direct services, that may have value but not in alignment with language of the \$20 million appropriation.

³⁴² LFC Report on Child Maltreatment at 8.

CYFD’s decision has drawn additional scrutiny. On October 14, 2025, the [OSA reviewed](#) select CYFD’s expenditures and found that \$3.81 million in shelter-related payments—which would include the contracts with AMIKids and Hope House—did not align with the legislature’s appropriation conditions.³⁴³ Based on these initial findings, OSA will expand the scope of CYFD’s annual financial and compliance audit.

c. CYFD leaders and legal practitioners alike recognize the inadequacy of congregate care.

Former Secretary Casados and Acting Secretary Valerie Sandoval have expressed to the *Kevin S.* arbitrator and the LFC that the state has not viewed congregate care facilities as a long-term solution, but rather as a necessary alternative to children staying in CYFD offices.³⁴⁴ For example, Secretary Casados acknowledged the limitations of AMIKids’ services, noting that they were not residential treatment centers, their staff were not licensed providers, and youth would need to receive community-based (rather than facility-based) therapeutic services.³⁴⁵ Remarkably, however, despite publicly acknowledging that congregate care fails to provide adequate and individualized support, CYFD is moving forward with plans to expand it. On October 20, 2025, CYFD announced its plans to open a new group home for foster children in Las Cruces.³⁴⁶ CYFD’s ongoing dependence on congregate care contradicts its public commitments and legislative rhetoric.

Former CYFD employees also broadly agree that group homes are unsuitable for children. One former PSD supervisor told the NMDOJ that congregate facilities are often ill-prepared to handle the youth, leading to frequent tensions between CYFD and the facilities. Another CYFD employee in a leadership position confirmed that the Department’s goal with AMIKids was never to improve youth mental health, job development, or educational outcomes, but rather to create the appearance that CYFD had solved its problem with office stays. One individual that works with families receiving services through an MCO

³⁴³ Shelter-related services were not the only contracts questioned by OSA. In total, \$7.06 million—62% of the expenditures reviewed—did not align with the Legislature’s intent.

³⁴⁴ Secretary Casados noted that the “multipurpose homes that we’ve created in Albuquerque for males and females are really just a solution that we came up with because of office stays.” Legislative Finance Committee Hearing Trans. 77:11-17 (Dec. 10, 2024) (statement of Sec. Casados); see also Trans. Valerie Sandoval 119:20-120:1 (Day 5 of Arbitration), *Kevin S. v. N.M. Children, Youth and Families Dep’t.* (Nov. 13, 2024) (indicating that AMIKids was expanded in response to criticisms to office stays).

³⁴⁵ Casados Trans. at 155:17-157:1 (Day 8 of Arbitration) (Nov. 22, 2024).

³⁴⁶ Esteban Candelaria, [CYFD plans to open new group home for foster children in Las Cruces](#), Santa Fe New Mexican. (Oct. 20, 2025).

emphasized the lack of programming at these facilities,³⁴⁷ succinctly stating, “it’s just warehousing children with behaviors.”

A youth attorney representing clients at Hope House relayed similar concerns to the NMDNJ. She recounted a case where a teen client, after running away and being raped, was refused re-entry by Hope House staff, who instead threw her a blanket outside and said, “this is what you get for running away.” The attorney also reported other antagonistic staff behaviors, such as holding a vacuum cleaner next to a child’s head to force them out of bed. Although Hope House employs a therapist, her clients infrequently engage with the therapist, and many refuse medications, contributing to the unstable environment.

d. Kevin S. Co-Neutral data underscores the consequences of CYFD failure to comply with congregate care safeguards.

As recently as August 18, 2025, the *Kevin S.* arbitrator noted in a remedial order that “CYFD has not made progress regarding use of congregate placements. Youth are now placed at Hope House and AMIKids, with some youth staying at those placements for longer than 90 days.”³⁴⁸ In the most recent *Kevin S.* annual report, CYFD repeatedly missed core settlement safeguards tied to congregate care:³⁴⁹

Table 7. CYFD performance regarding key congregate care safeguards and requirements. Compiled by NMDNJ from Kevin S. Co-Neutral 2024 Annual Report.

Targeted Outcome	Settlement Requirement	2024 CYFD Performance
Clinical congregate care limited to medically necessary cases	Clinical medical necessity must be reviewed every 30 days	31% on time (120/391 reviews)
30-day Individualized Planning Meeting (IPP) meetings for clinical congregate care	IPP held every 30 days to plan steps toward discharge	13% completed (10/77); 0% included all required attendees
Non-clinical congregate care only when in the child’s best interest	Best-interest determinations must be reviewed every 90 days	4% on time (5/141 reviews)

³⁴⁷ CYFD often notes the difficulty in mandating services for children over 14. The Children’s Mental Health and Developmental Disabilities Code presumes children 14 or older have capacity to consent to or reject therapy, drug treatment, or psychotropic medications. See NMSA 1978, § 32A-6A-15, -16. However, Dr. George Davis points out that when services are easily accessible, encouraged, and discussed with youth collaboratively rather than coercively, wider acceptance follows.

³⁴⁸ [Arbitrator’s Remedial Order. No. 2](#) 9, *Kevin S. v. N.M. Children, Youth and Families Dep’t.* (Aug. 18, 2025) (Peifer, Arb.).

³⁴⁹ *Kevin S.* 2024 Co-Neutrals’ Annual Report at 75–85.

CYFD’s noncompliance lapses have a direct and adverse impact on New Mexico children in congregate care facilities. Aside from CYFD office buildings, congregate care facilities—including out-of-state residential treatment centers, in-state acute hospital placements, shelters, and group homes—were the second most frequent location of critical incidents.³⁵⁰ Incidents included children running away from facilities; behavioral management problems; allegations of abuse and neglect; and threats of self-harm. The majority of reports received for children in congregate care facilities were for allegations of physical restraint, chemical restraint, or seclusion.³⁵¹

Kevin S. Co-Neutrals identified 182 allegations of restraint and/or seclusion that occurred at congregate care facilities between October and December of 2025 alone. The majority of children experienced two or more incidents of restraint or seclusion (81%), with an average of seven incidents per child.³⁵² FACTS records and CYFD data on congregate placements demonstrated the following restraint and/or seclusion incidents by type:

Table 8. *Restraint and seclusion in congregate care facilities, October-December 2025. Reproduced from Attachment D, Additional Analysis of Critical Incidents, Kevin S. Co-Neutral status report (January 30, 2026).*

Type of Incident	N	%
Physical Restraint	131	72%
Chemical Restraint	26	14%
Both physical and chemical	18	10%
Seclusion	7	4%
Total	182	100%

e. Law enforcement reports document widespread safety risks in Bernalillo County congregate care settings.

The NMDNJ analyzed nearly 200 law enforcement calls for service at five Bernalillo County congregate care facilities—two shelters, two multi-service homes, and a residential treatment center. Law enforcement records mirrored many of the dangers identified by child psychiatrists and Co-Neutrals: resident-on-staff and peer-to-peer violence; threatened self-harm and suicidal/homicidal ideations; inappropriate relationships with staff; consumption of alcohol and possession of other contraband; and frequent resident elopements. A [cross-section of the investigations](#) include:

³⁵⁰ January 30, 2026, Kevin S. Report, Attachment D. Additional Analysis of Critical Incidents, at 5.

³⁵¹ January 30, 2026, Kevin S. Report, Attachment D. Additional Analysis of Critical Incidents, at 5-7.

³⁵² *Id.* at 7.

- [November 8, 2019](#), at Sequoyah Adolescent Treatment Center—Video evidence of numerous instances where a 28-year-old staff member was seen kissing and fondling a 15-year-old youth in treatment.
- [October 9, 2022](#), at New Day—A 16-year-old resident disclosed having homicidal thoughts toward other residents. Staff confirmed the youth takes multiple medications but had run out of medication two weeks prior.
- [January 23, 2023](#), at New Day—A runaway report of a 16-year-old with a felony warrant was made two months after the elopement.
- [July 2, 2023](#), at New Day—A 17-year-old resident broke windows and damaged electronics after an altercation with a 12-year-old peer with developmental disabilities and the cognitive capacity of a young child.
- [February 25, 2025](#), at Hope House—A 14-year-old resident eloped from the residence. Reports indicate that the child had run away on two prior occasions, including one instance in which she was sexually assaulted.
- [March 9, 2025](#), at Hope House—A 17-year-old pregnant resident engaged in disruptive behavior and made homicidal statements. The resident was transported to the hospital for a mental health evaluation.
- [April 6, 2025](#), at Hope House—A female resident attempted to strangle herself with an item of clothing, and staff failed to call for medical assistance for two hours after the incident. A police report noted:

NARRATIVE

On April 06, 2025, at approximately 2225 hours, I was dispatched to 4405 Andrew Dr NE in reference to a suicidal subject at a group home. Comments on the call advised a female resident had gone to the bathroom to take a shower and attempted to strangle herself in the bathroom with items of clothing. Comments also advised there was a two hour time delay from when the incident occurred to when the reporting party called 911 and that the female was currently asleep in her bedroom.

Most stakeholders that interact with New Mexico’s child welfare system—clinical experts, former CYFD employees, law enforcement, legal practitioners, Co-Neutrals and the Legislature—conclude that congregate care facilities are ill-equipped to provide safe, therapeutic, or developmentally appropriate care.

2. Gaps in CYFD’s approach to investigating and tracking abuse and neglect in congregate care facilities.

CYFD’s Licensing and Certification Authority (LCA) plays a critical role in ensuring the safety of children placed in congregate care and behavioral health settings. It is responsible for licensing these facilities, monitoring their programming, and ensuring the provision of

trauma-responsive care.³⁵³ Yet, the Co-Neutrals report that CYFD has provided no written policies or procedures governing how LCA investigates allegations of abuse or neglect in facilities, even though such investigations involve high-risk incidents affecting children's safety.³⁵⁴ Instead, LCA leadership has only verbally described their approach, noting that they first defer to law enforcement on potential criminal matters, then determine what, if any, further assessment they will conduct from a licensing perspective.

Although LCA is expected to staff SCI reports within 24 hours, develop an action plan, visit the facility, and conduct interviews and reviews within 72 hours, these expectations remain undocumented and structurally siloed.³⁵⁵ Critically, LCA's investigations and substantiations of abuse or neglect are kept in its internal SharePoint system and not incorporated into FACTS, meaning that investigators, PPWs, and other CYFD staff responsible for children's care cannot access this information. As a result, serious allegations, including substantiated findings, do not enter the central child welfare data system and are not counted in New Mexico's statewide reporting on maltreatment of children in state custody.

This fractured process has profound safety implications. Because substantiated findings by LCA are not recorded as abuse or neglect by caregivers of children in state custody, perpetrators can continue working directly with children in other facilities across New Mexico. The state has not produced to Co-Neutrals any documented policies or procedures detailing a formal mechanism to screen out or disqualify individuals in these circumstances.³⁵⁶ Moreover, by isolating investigative findings within LCA and outside CYFD's primary data systems, the State lacks the ability to identify patterns of maltreatment across facilities, detect repeat offenders, and address recurring threats. To fix these deficiencies, LCA must adopt and publish clear investigative policies, ensure that all investigative outcomes—particularly substantiated findings—are entered into FACTS, and implement a statewide, enforceable process to prevent individuals who have abused or neglected children from working in any licensed facility.

These gaps in oversight underscore how critical it is to identify safety risks in congregate facilities before they escalate. The following case study illustrates just how dangerous these environments can become for the youth placed in them.

³⁵³ January 30, 2026 Kevin S. Report, [*Attachment E. Screening and Investigation of Reports of Child Abuse and Neglect*](#), at 5.

³⁵⁴ *Id.*

³⁵⁵ *Id.* at 6.

³⁵⁶ *Id.*

3. Case Study: “Joshua H.”

On April 12, 2025, 16-year-old Joshua H.—whose name has been changed to ensure his privacy and that of his family—committed suicide at the AMIKids multi-service home in Albuquerque. During Joshua’s 22 months in state custody, CYFD and AMIKids each had opportunities to recognize his troubled trajectory and take more meaningful action to positively alter the course of his life. Neither did.

a. Joshua’s life and placement history.

Joshua H. (YOB: 2009) was the third of six children born to Mercedes G. and George H. He had two older brothers, Dominic H. (YOB: 2005) and Michael H. (YOB: 2007), and three younger siblings, Austin H. (YOB: 2014), Jorge H. (YOB: 2018), and Erika H. (YOB: 2023). Joshua was described by those around him as “really vivacious, very funny, outgoing, talkative . . . just a really sweet kid.”³⁵⁷ One individual with whom Joshua stayed in early 2025 stated that for those who invested empathy and compassion, Joshua “was like an open book—he’d tell you anything.”³⁵⁸

Joshua’s pleasant demeanor belied his difficult upbringing. Prior to the removal from his biological parent’s custody in June 2023, Joshua’s family life was fraught with drug addiction, unstable housing, food insecurity, recurring criminal activity, and chronic neglect. Between March 2015 and February 2020, CYFD received six referrals alleging neglect of Joshua and his siblings. In each instance, CYFD deemed the allegations unsubstantiated and made only occasional referrals to services. Each of the underlying issues presented to CYFD during this period—insufficient pediatric care, mental health challenges, and lack of proper parental supervision—eventually reemerged and formed the basis for removal of the children. Between 2022 and 2023, Mercedes and George were arrested on at least two occasions for shoplifting and narcotics possession. Joshua was often required to assist his mother in her shoplifting schemes.

On June 22, 2023, deputies responded to a property in Bernalillo County where George and Mercedes were staying with four of their sons, including Joshua, and six unrelated adults. Conditions at the residence were horrific. Deputies located drug paraphernalia (syringes and pipes) within reach of the children, animal feces in sleeping quarters, exposed electrical wires, and rotten food. Deputies seized fentanyl, cocaine, heroin, methamphetamine, and multiple firearms. George and Mercedes were arrested for child abuse. A BCSO deputy noted in their report:

³⁵⁷ NMDNJ interview of George H.’s cousin, Trans. 7:13-16 (May 12, 2025).

³⁵⁸ NMDNJ interview of Joshua H.’s friend’s mother and girlfriend, Trans. 51:21-52:3 (May 13, 2025).

While I was conducting a welfare check of the residence, the air felt “heavy” with little ventilation going through the residence. There was also a musky smell in the house with the temperature well above room temperature. With the poor ventilation and air circulation in the residence, evidence of a high amount of fentanyl use in the residence, the children sleeping next to the bedrooms with the high amount of fentanyl, and the paraphernalia easily accessible to the children being on top of reachable dressers, trashcans and shelves, the occupants placed the children a highly dangerous situation of drug exposure that could have cause significant health defects and possible death. The children are old enough to possess the motor skills to walk into the bedrooms and face a high risk of drug exposure. [REDACTED] and [REDACTED] were aware of the drug use in the house and also participated as well knowing the children faced that danger.

The children were removed from the home and placed with their paternal aunt and uncle, Carmella H. and Robert H. On July 5, 2023, CYFD filed a petition in Children’s Court seeking custody of Joshua, Michael, Jorge, and Austin, noting George and Mercedes’ failure to meet their basic needs. On July 17, 2023, the court found that George and Mercedes were unable or unwilling to provide adequate supervision and care for their children, and that the children should remain in CYFD’s legal custody.

Carmella and Robert welcomed Joshua and his three siblings into their home and secured critical medical and emotional services for them. Joshua was enrolled in Rio Rancho High School³⁵⁹ with an IEP, the children regularly attended medical and developmental appointments through UNMH Healthy Beginnings, and therapy services were obtained through Family Workshop. As part of the family treatment plan created between CYFD and the family on October 16, 2023, CYFD’s obligations to ensure Joshua’s well-being are clearly stated. In order to assess and maintain Joshua’s mental health, CYFD would ensure that he participate in mental health screenings, and would “provide referrals, follow progress, and obtain records.”

Case Participant: [REDACTED]	Individual Child Plan
Desired Outcome: Assess and maintain mental health.	
Resp. Client: [REDACTED]	
Steps/Client: [REDACTED]	will participate in mental health screening and recommendations.
Resp. CYFD Party: [REDACTED]	
Steps/CYFD: The Department will provide referrals, follow progress, and obtain records.	
Estimated Completion Date: 04/27/2024	Outcome: Ongoing

According to CYFD’s permanency hearing report, Joshua informed his CYFD PPW that he would “try therapy” and indicated that “it might be good for [him].” Joshua and his siblings continued residing with Carmella and Robert, and the children’s permanency plan remained reunification with George and Mercedes. In November 2023, a new CYFD PPW was assigned to Joshua, his second in just over four months.³⁶⁰ In December 2023, George and Mercedes—

³⁵⁹ Joshua had only attended school sporadically since the COVID-19 pandemic, and Joshua’s 8-year-old sibling had never attended school.

³⁶⁰ The county office manager overseeing Joshua’s case was the same county office manager responsible for a premature trial home visit in Daniella C.’s case.

while still subject to a CYFD plan to address homelessness and substance abuse issues—gave birth to a drug-exposed sixth child, Erika.³⁶¹

Carmella and Robert experienced ongoing problems with CYFD. Upon initial placement of the four siblings, CYFD dropped the children off without any clothes, personal belongings, or information about next steps. The following day, ahead of Jorge’s urgent care visit for a bacterial infection, Carmella sought the children’s birthdates from CYFD. The Department did not respond for nearly a week. CYFD was similarly unhelpful in ensuring the children were enrolled in school for the upcoming year. The PPW stated she could not confirm the children’s registration status because it was summer break. Carmella simply called the Albuquerque Public Schools (APS) administrative office and validated the information herself. She credits Rio Rancho Public Schools—not CYFD—for the children’s progress and implementation of IEPs. Carmella also described to the NMDOJ the persistent difficulties she encountered when trying to work with CYFD to secure reliable transportation for the younger children.³⁶²

These frequent barriers made Carmella and Robert [lose trust in CYFD](#). In February 2024, Carmella [authored an email to Governor Lujan Grisham](#) to voice concerns about CYFD’s handling of her nephews’ cases. Carmella noted the importance of CYFD doing their part for the children, and stated:

“I truly feel like the past 8 months I have done more of CYFD’s job than I had done my own at times and that is extremely discouraging for someone that is trying to do the right thing.”

Carmella ended the correspondence by warning of serious deficiencies within CYFD, and the negative ramifications for her nephews, as well as “all the other kids and families in [New Mexico] that are experiencing the same hurdles”:

³⁶¹ Erika was removed from George and Mercedes’ custody due to their unsafe lifestyle and placed with Mercedes’ cousin.

³⁶² NMDOJ interview with Carmella and Robert, Trans. 32:3-8, 33:1-18, 33:22-34:15, 41:10-42:2, 43:9-44:1, 77:4-79:11 (May 16, 2025).

I understand that there are policies in place that I may not be privy to, but something has to change with this system as we are one in a hundred of families that are going through this same thing and it's the children who are suffering the most by the lack of support that CYFD is either not willing or unable to provide. I write this letter to highlight the consistent issues we have faced while dealing with the department and with the hope that something changes not only for my nephews but also for all the other kids and families in NM that are experiencing the same hurdles. I will not allow this to be my nephew's story or to let them be some news article of how CYFD is failing yet once again. I will continue to advocate for them until someone has the compassion to hear us and address these ongoing concerns.

Meaningful support by CYFD to Carmella and Robert in caring for their nephews never materialized. Instead, Joshua had continued trouble acclimating to the new placement with his relatives. Carmella and Robert had familial rules and structure that Joshua was unaccustomed to as a result of the chaotic lifestyle he had lived with his parents. Throughout late 2023 and into early 2024, Joshua began to distance himself from his aunt and uncle. Carmella noted that Joshua held resentment toward them because he wanted to return with his biological parents.³⁶³ Joshua voluntarily left his Carmella and Robert's residence in late March 2024, when he was fifteen years old.

After leaving Carmella and Robert's home, Joshua had multiple temporary living situations. Between roughly April and November 2024, Joshua would sleep at friends' houses, reside in different shelters, and frequently stay at the CYFD offices. In a [June 14, 2024 report](#) by Joshua's youth attorney, Joshua was staying at Amistad Youth Shelter, receiving necessary medical services, holding a job, and maintaining a good relationship with his PPW. The report noted that Joshua's parents had done little to address the causes of their abuse and neglect, and that Joshua "seems more fatalistic and seems to realize he cannot control what his parents do." By late July 2024, Joshua remained at a "non-relative placement." In a July 29, 2024 permanency report, CYFD's PPW indicated that Joshua was attending weekly therapy:

5. [REDACTED] will participate in mental health screening and recommendations. [REDACTED] attends therapy weekly at Family Workshop in Rio Rancho. His therapist is [REDACTED]. He really enjoys attending and believes it helps.

According to Joshua's attorney, Joshua began staying at AMIKids in roughly November 2024, and remained there until December 2024 when he left the facility to stay with his

³⁶³ *Id.* at 21:18-22:1.

girlfriend, Raylene T. In her interview with the NMDNJ, Raylene recalls staying with him at a friend's house over "Christmas-time" in 2024. Also in December 2024, a former PPW with knowledge of Joshua's case recalled that Joshua "quit or got discharged" from therapy. By early February 2025, Joshua began staying with a friend's mother, and remained at her residence until roughly March 5, 2025, when he returned to AMIKids.

During this time, Joshua's statements and behavior at AMIKids suggested that he was emotionally withdrawn and experiencing a deep sense of dejection. Joshua's friend's mother remembered many times that he would be crying at night "because he just felt like he didn't fit in anywhere." She recalled another instance where Joshua rhetorically asked her, "If I was missing, do you think anybody would be putting fliers up for me?"³⁶⁴ Raylene confirmed to the NMDNJ that Joshua had disclosed a prior suicide attempt.

Joshua's worsening mental health became increasingly evident while at AMIKids. AMIKids staff notes from April 8, 2025, reflect that Joshua refused to eat and remained on his phone in his room. The evening before his death, Joshua was reprimanded for bringing a THC

vape into the facility. On April 11, 2025, Joshua and Raylene spent the day together at the mall. The two got into an argument but made up before Joshua returned to AMIKids. That night, Raylene remembered him texting "creepy stuff," thanking her for being in his life, and expressing how much she meant to him. After Raylene fell asleep, she received another message from Joshua stating, "I really need to talk to someone . . . I don't want to be here no more. I'm losing everyone."³⁶⁵

b. Joshua's death and AMIKids' operational breakdowns.

On April 12, 2025, at 8:47am, NMSP officers were dispatched to a juvenile suicide attempt at AMIKids. An AMIKids staff member relayed that a male—later identified as Joshua—had

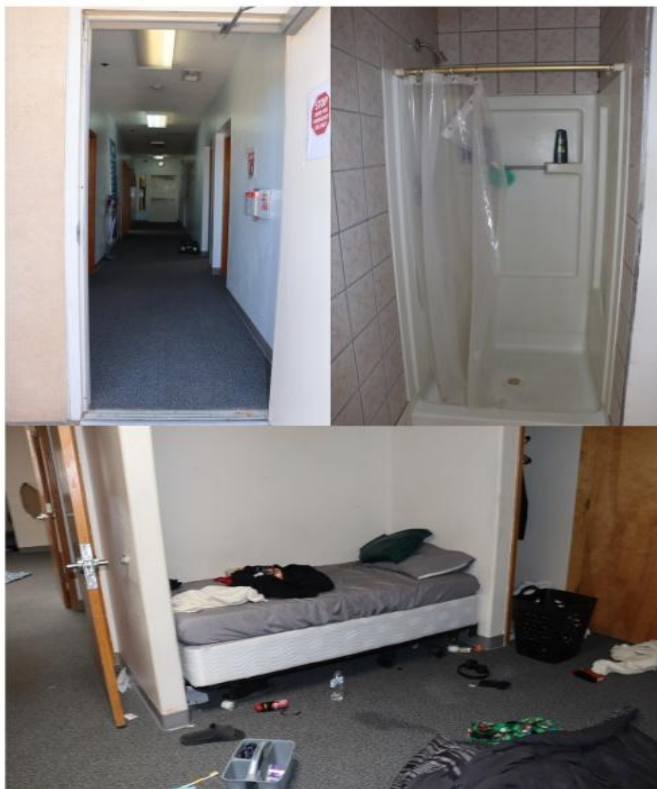


Figure 27. Photos from NMDNJ investigation on April 12, 2025. Clockwise from top left: Hallway at AMIKids; bathroom where suicide occurred; and resident living quarters.

³⁶⁴ NMDNJ interview of Joshua H.'s friend's mother and girlfriend, Tran. 40:20-23, 42:12-16 (May 13, 2025).

³⁶⁵ *Id.* at 46:13-48:3.

hung himself from a towel in the facility bathroom. EMS arrived on scene to initiate life-saving measures. Law enforcement dispatch notes painted a chaotic picture, with multiple people on scene “freaking out” and not following instructions. At 9:16 a.m., after being unable to revive Joshua, EMS ceased performing CPR. Joshua was pronounced deceased by the Office of the Medical Investigator at 10:10 a.m.

NMSP officers obtained statements from AMIKids staff who worked at the group home. A staff member reported that on the morning of the incident, she observed Joshua grab a towel and go into the bathroom. Other residents informed her that Joshua had been in the bathroom for “a few minutes,” and when they checked on Joshua, he didn’t answer. The staff member told law enforcement she didn’t find anything suspicious.³⁶⁶ Two youth opened the bathroom door to check on Joshua, and observed him hanging from a towel, elevated off the ground.

NMSP officers also spoke with the youth that found Joshua. One 16-year-old described having warned staff about Joshua “either hanging himself or doing something suspicious because he went into the bathroom with a dry towel and never turned on the shower.” Another of the residents turned over a suicide note left by Joshua and recalled that he had been arguing with his girlfriend prior to entering the bathroom. Neither NMSP nor OMI found any signs of foul play, and an autopsy confirmed that the cause and manner of death was self-inflicted hanging by suicide.

In response to Joshua’s death, CYFD’s LCA initiated an investigation on April 14, 2025. By May 9, 2025, the LCA determined that AMIKids was noncompliant with regulations governing multi-service homes. In a Notice of Investigation Report and Sanction, CYFD identified five specific violations of licensing standards:

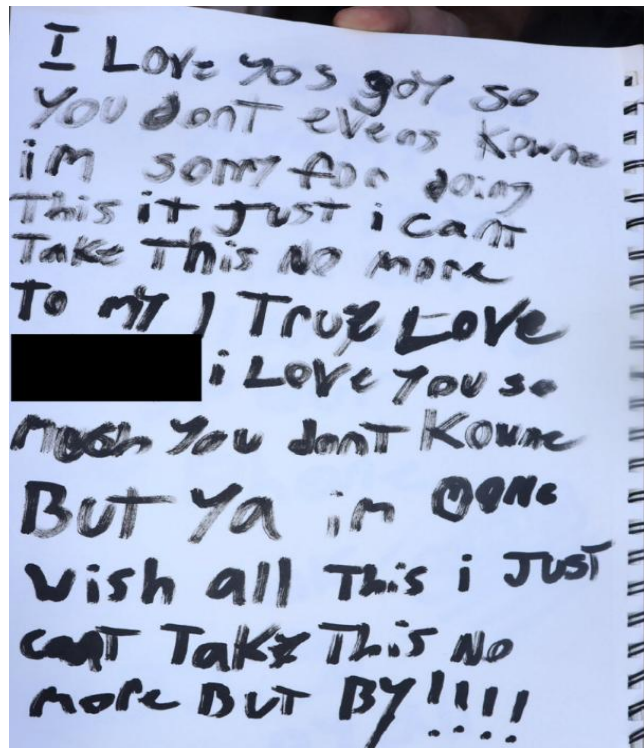


Figure 28. Joshua H.’s suicide note found at AMIKids.

³⁶⁶ A subsequent review of AMIKids video footage showed that Joshua was in the bathroom for more than a “few minutes,” having entered at 7:40 a.m., and being found by other youth at 8:36 a.m.

- i. Staff and residents did not adhere to rules regarding possession and use of personal electronic devices. Video showed that staff members were on their cell phones for extended periods of time, and Joshua was allowed to enter the bathroom with his cell phone against policy. AMIKids staff also failed to render timely aid as required.
- ii. AMIKids' policies for responding to emergencies, including medical crises and suicide prevention were inadequate or inconsistently implemented. Staff also lacked training on how to respond to such incidents.³⁶⁷ The investigation found:

AMIKids policy and procedure, *Medical Services -MSAQ*, states, "Any Team Member who becomes aware of a youth exhibiting a need for emergency medical services will immediately contact 911 and render aid within the scope of their training until Emergency Medical Services arrives." See Exhibit F, Medical Services-MSAQ, 04.12.2024. Checking for signs of life is the minimal response in First Aid training and within the staff's scope of training. Neither Staff # 1 nor Staff #2 entered the bathroom when the Subject was immediately discovered to check for signs of life, nor did they render aid. This was confirmed by LCA after a review of the video footage, and by Resident #2's interview, who went into the bathroom to check on the Client for vital signs.

- iii. The facility did not provide sufficient supervision to ensure the health and safety of its residents. The checks³⁶⁸ and monitoring required were not performed appropriately, and staff failed to timely respond to concerns raised by other residents:

AMIKids provided a skin check log dated April 12, 2025, which documents that skin checks were performed at 06:00, 06:15, 06:30, 07:00, 07:30, 0800, and 08:30, and that all seven residents were accounted for. See Exhibit J, Skin Checks Log. Additionally, LCA reviewed video footage from those time frames, and the video only supports two possible resident skin checks during the above time frames. In addition, between 07:40 and 08:36 a.m., during the time the Client was in the bathroom, no staff member could be seen checking on the Client.

- iv. AMIKids staff files were incomplete. In one instance, a staff member had employment reference checks completed well after their hiring date.

³⁶⁷ Joshua's death was not the first time that AMIKids would have been called upon to exercise their suicide prevention protocols. On March 10, 2025, records show that Bernalillo County Sheriff's deputies were called to AMIKids in relation to a youth who cut himself and threatened suicide.

³⁶⁸ AMIKids staff were required to conduct 'Skin Checks,' which are routine, intermittent observations designed to monitor the safety, health, and well-being of youth in their care.

- v. AMIKids failed to maintain records related to training of staff in critical areas, including child abuse and neglect and emergency equipment.

To avoid further licensure consequences, CYFD directed AMIKids to fulfill a directed corrective action plan (DCAP), mandating the completion of 12 remedial actions.

c. AMIKids' red flags before Joshua's death.

CYFD had ample warning that AMIKids was not suitable for serving adolescents with complex behavioral needs well before Joshua's death in April 2025. The NMDOJ interviewed Harlena Reed, a former Deputy Director of the LCA, who detailed numerous red flags about AMIKids that had been raised with CYFD leadership. In her capacity, Ms. Reed was responsible for approving and monitoring shelters, group homes, and similar congregate care facilities throughout New Mexico. Ms. Reed told the NMDOJ that she frequently expressed concerns regarding AMIKids' expansion into Bernalillo County, in part due to the organization's traditional strategic focus on juvenile justice rather than residential treatment. She explained that when she reviewed AMIKids' programming, it was juvenile-delinquency oriented, which was inconsistent with best practice therapeutic treatment models. In other words, AMIKids' services were better suited for incarcerated youth than children needing a stable home.

Ms. Reed's concerns were well-founded. AMIKids had an existing presence in New Mexico with locations in both Cuba and Farmington. The Cuba location ultimately closed after being sanctioned and having its admission frozen following an incident where a staff member assaulted a child. By the time Ms. Reed began working at CYFD, the Farmington facility had also been sanctioned after a resident sustained significant injuries. [Secretary Casados was aware of existing sanctions](#) when AMIKids sought approval to open a new facility in Bernalillo County. Given AMI's poor track record in the state, Ms. Reed questioned the wisdom of placing a concentrated number of vulnerable youth into an organization that had recurring supervision and other issues. In spite of the objections raised, CYFD leadership approved AMIKids' expansion. Ms. Reed recalled it feeling like "a preordained outcome."

Ms. Reed explained that AMIKids' disregard for regulatory standards was emblematic of a broader pattern within CYFD. She noted instances where [Secretary Casados would override regulations](#) prohibiting expansion of services while a provider was on sanction or suspension. She cited a constant battle with providers and CYFD colleagues to effectively accomplish her oversight responsibilities. Ultimately, Ms. Reed left CYFD in March 2024, expressing her reasons in a [resignation letter](#). Ms. Reed ended by saying:

“For the convenience of Protective Services Division and due to barriers they face with placing children in foster homes, LCA has been pressured and bullied into rushing the licensing of providers, keeping providers open who repeatedly failed to meet regulatory standards, and questioned about holding providers accountable for their failures to meet regulatory standards. This is not the position that any regulatory entity should be put into, as it defeats the purposes and goals of having a regulatory body. I can no longer effectively do my job and I cannot in good conscious join the forces of mediocrity.”

Problems quickly surfaced when AMIKids began operations in Bernalillo County. In a September 2024 article in the Santa Fe New Mexican, it was reported that 16 staff members had left AMIKids since it opened in May 2024.³⁶⁹ Workforce constraints were also brought to the attention of BCSO deputies dispatched to a physical fight between residents on June 23, 2024. [AMIKids staff communicated](#) to deputies that they were “short-staffed” and faced challenges with youth bringing drugs into the facility. [The staff member also discussed](#) threats by youth, and told deputies that while the facility’s resident capacity was 12, but they were “struggling with four.”

Additionally, the DCAP imposed on AMIKid’s after Joshua’s death was not the first time AMIKids was under the microscope. In fact, the May 2025 DCAP cited a “pattern of behavior,” referencing prior substantiated allegations on October 4, 2024, and remedial measures including “issuance of a corrective action plan and technical assistance report”:

Further, AMIKids has only been licensed for twelve (12) months and has had two CAPs to date. There is a clear inconsistency in the understanding and implementation of policies and procedures, which is not aligned with expected facility practices. While AMIKids facility and its staff require overall improvement in the supervision and training of both personnel and residents, this incident is primarily the result of a failure to act by the two staff members who were on duty at the time.

At the time of Joshua’s death in April 2025, AMIKids was still operating despite repeated internal warnings, severe staffing shortages, and prior documented sanctions.

d. CYFD’s gaps and deficiencies in Joshua’s case management.

CYFD’s decision to allow AMIKids to expand despite known sanctions and significant operational concerns reflected a serious lapse in judgment. But the Department’s failures in Joshua’s case extended well beyond that misstep: CYFD failed Joshua in five additional, critical ways.

³⁶⁹ Esteban Candelaria, [Albuquerque group home for foster youth sees huge staff turnover](#), Santa Fe New Mexican (September 25, 2024).

First, according to Joshua’s aunt and uncle, CYFD presented Joshua placement options that were not feasible, which only served to encourage him to leave their household. CYFD’s communication with Joshua about an “independent living”³⁷⁰ environment played a role in convincing him to prematurely depart a supportive, family-based placement with Carmella and Robert. Carmella recalls Joshua’s PPW talking extensively with him about independent living options. She noted that Joshua was intent on pursuing these options, and when he learned about them, “it was like he gave up in [our] household and he was trying to get to that age where he could go independent.”³⁷¹

When Joshua left Carmella and Robert’s home in March 2024, he had only been 15 years old for two months. Under any CYFD arrangement constituting “independent living,” Joshua would not have qualified for at least another 10 months. By all accounts, Carmella and Robert provided Joshua and his siblings a stable, supportive, and loving environment. CYFD did not help Joshua adjust to his new environment or understand the value of his aunt and uncle’s household boundaries, instead frequently and hastily promoting “independent living” and suggesting that the home may have had “too much structure.”³⁷² The disconnect between the placement options identified for Joshua and their eligibility criteria led to a significant gap in time where Joshua lived a nomadic lifestyle without receiving the necessary support he required.³⁷³

Second, toward the end of Joshua’s life, CYFD neglected to ensure the continuation of vital mental health resources. CYFD’s family treatment plan required the Department to assess and maintain mental health services for Joshua by providing appropriate referrals and monitoring his progress.³⁷⁴ While CYFD’s permanency reports throughout much of 2024 noted that Joshua had been attending therapy at Family Workshop in Rio Rancho, it is believed that he ceased attending sessions toward the end of the year. A former CYFD permanency supervisor told the NMDNJ that CYFD was aware of Joshua’s mental health struggles and unstable living situation after leaving his aunt and uncle’s home. Joshua’s fragile mental state, combined with his withdrawal from therapy, should have prompted

³⁷⁰ “Independent living” options take different forms. A Planned Permanent Living Arrangement (PPLA) is a permanency plan for youth 16 and older when other plans are deemed inappropriate. CYFD Permanency Planning Proc. PR 13, §§ 11, 13.5. Independent Living Placement Status (ILPS) permits youth who are 17 and older and meet certain criteria to become their own vendors for maintenance payments. CYFD, [Youth Servs. Procedures](#) (8.10.9 NMAC) PR 18, §§ 5–6 (2016).

³⁷¹ NMDNJ interview with Carmella and Robert, Trans. 51:7-20; 52:25-54:15 (May 13, 2025).

³⁷² *Id.* at 52:8-10.

³⁷³ A September 10, 2024, amended court report noted that CYFD was requesting a change of plan for Joshua to independent living. Yet permanency hearing report dated December 10, 2024, indicated that Joshua’s recommended permanency plan remained reunification with his biological parents.

³⁷⁴ This requirement was adopted in the October 16, 2023, family treatment plan and reiterated throughout permanency reports in July and December 2024.

urgent action from CYFD. It did not. In a [September 2025 fatality review](#) conducted by the Kevin S. Co-Neutrals, it was revealed that Joshua “repeatedly asked for developmentally appropriate assistance: a job, schooling, and behavioral health care.”³⁷⁵ CYFD failed to facilitate these fundamental resources. Addressing both Joshua’s case and the broader challenges facing children in state custody, the fatality review stated plainly:

Therapeutic and supportive services were not provided consistently and, in some instances, not provided at all. The records exemplify the inadequacy of behavioral health services for children in state custody.

Third, the apparent decline in Joshua’s mental health coincided with an untimely reassignment of CYFD PPW. Multiple individuals confirmed to the NMDOJ that Joshua’s PPW throughout 2024 and into 2025 worked very hard for Joshua, and that they had established a positive relationship. Around mid-March 2025, that PPW left her role and transferred elsewhere within the Department. As explained by a former CYFD supervisor who spoke to the NMDOJ, this left Joshua without a PPW “for quite some time.” Joshua’s departing PPW completed a written case transfer summary, but no meeting was held with supervisors and the newly assigned PPW to review the case. This former permanency supervisor explained that standards of practice require “a case transfer staffing and warm handoff,” but that these steps rarely occur at CYFD because staff are so overwhelmed. While there were sporadic video visits between Joshua and a senior PPW whose team would be taking on Joshua’s case, Joshua was never visited in-person at AMIKids, and the case was never officially transferred prior to his death. Carmella also confirmed that at the time of her interview with the NMDOJ in May 2025, her family and Joshua’s siblings had not had a home visit from a CYFD PPW since February 11, 2025, in violation of policy.³⁷⁶

Fourth, CYFD routinely failed to follow legally-obligated permanency timelines. Timely achievement of a permanency plan promotes stability and reduces system involvement and associated trauma. In September 2024, the court issued an order reflecting CYFD’s intent to change the permanency plan for the children: (1) Michael, to guardianship, (2) Austin and Jorge, to adoption, and (3) Joshua, to independent living. However, three months later, CYFD submitted a report to the court that still listed reunification as the recommended plan for all four children. By December 2024, Joshua and his siblings would have been in foster care for over 17 months, mandating that CYFD move to terminate George and Mercedes’ parental rights.³⁷⁷ Of course, this would have also required CYFD to cease

³⁷⁵ The Co-Neutrals Fatality Review covers Joshua’s case and that of another recently-deceased child.

³⁷⁶ NMDOJ interview with Carmella and Robert, Trans. 44:24-45:1 (May 16, 2025).

³⁷⁷ See NMSA 1978, § 32A-4-29(G) (stating that CYFD must file a motion to terminate parental rights, subject to certain exceptions, if a child has been in foster care for 15 of the prior 22 months).

pursuing reunification as a permanency plan.³⁷⁸ CYFD did note in its permanency hearing report on December 10, 2024, that it was planning to file for a TPR. However, as of May 2025, CYFD had not filed the required motion to initiate TPR proceedings.

Fifth, in the aftermath of Joshua's death, the *Kevin S.* Co-Neutrals found that CYFD's response was underwhelming and insufficient to ensure the prospective safety of those residents who remained at AMIKids. The Co-Neutrals found:

The administrative response to [REDACTED] and [REDACTED] deaths by CYFD was fully inadequate, marked by incorrect information, poor inter-agency coordination and the slow exercise of post-fatality investigation and oversight. Symptomatic of this approach, CYFD often pledged to provide key information and reports to the Co-Neutrals, which typically did not arrive as promised, if at all. In [REDACTED] case, there was inadequate follow-up with the institution where he resided to ensure the safety and well-being of the remaining residents and to correct failures related to supervision and safety.

Through its investigation, the NMDOJ uncovered the same transparency concerns raised by the Co-Neutrals. The NMDOJ requested additional records related to Joshua's time in CYFD legal custody and experience at AMIKids. CYFD failed to provide the totality of these records. CYFD was swift to produce documents that shifted blame for Joshua's circumstances onto AMIKids, yet conspicuously withheld records that would have revealed its own failures in the case.

Congregate care settings, particularly those lacking clinical oversight, function as reactive custodial solutions rather than therapeutic, family-centered environments. Overuse of these placements has resulted, and will continue to result, in significant harm to our youth. There is a human cost to choosing convenience over trauma-informed care.

³⁷⁸ No circumstances existed for CYFD to decline to initiate TPR proceedings. George and Mercedes were not making meaningful progress on treatment plans. In fact, Mercedes was rearrested on May 8, 2025.

IV. EXPERT REVIEWS OF CYFD PRACTICES

As part of its investigation, the NMDOJ consulted with two experts in child protective services—[Dr. Melissa Moyer](#) and [Dr. Mayola Miranda](#). Dr. Moyer is the director of the masters of social work program at Eastern New Mexico University. She holds a doctorate in social work, maintains a clinical license, and previously worked for CYFD as a county office manager. She has served as an expert witness in children wrongful death cases in New Mexico and is qualified to assess CYFD’s compliance with statutory, regulatory, and policy obligations. Dr. Moyer thoroughly reviewed CYFD’s performance in six of the case studies discussed above—Sarah M., Amelia S., Gloria F., Daniella C., Lindsay N. and Diego T., and Charlotte A. Her expert opinions appear in each respective section and illustrate CYFD’s consistent failure to follow best practices in child welfare. Many of these failures contributed to harmful or deadly consequences for defenseless children.

Dr. Miranda is a licensed clinical social worker with over 25 years of experience in both the public and private sectors. She holds a doctorate in public administration and a master’s degree in social work. She has extensive hands-on experience in the child welfare system, having served as a protective services social worker and supervisor. Dr. Miranda examined CYFD’s investigative policies and departmental practices and compared them to those of child protective agencies in other states. Her review found that many of CYFD’s current practices fall well short of generally accepted child welfare standards.

Dr. Miranda authored a report containing her findings. The report is structured around five key themes: (1) deficient child abuse and neglect investigations, (2) errors in safety and risk assessments, (3) safety of CARA infants, (4) ineffective use of safety plans and respite care, and (5) challenges in workforce recruitment and retention. Dr. Miranda also offers targeted recommendations for improvement.

1. Deficient child abuse and neglect investigations.

Dr. Miranda flagged eight common problems in the abuse and neglect investigations that she reviewed. Her findings include:

a. Incomplete and superficial investigations

Dr. Miranda noted that CYFD investigations frequently fell short of basic investigative standards. CYFD investigators often failed to interview people reporting potential child abuse, leading to critical information gaps and inaccurate safety assessments. Investigations lacked detailed injury documentation, ignored relevant law enforcement findings, and failed to assess abuse or neglect beyond the initial allegations. In instances where one parent was not directly abusing their child but had knowledge of or condoned abuse, CYFD investigators routinely designated that parent as “non-offending.” As a result of

these collective failures, children were often left in unsafe environments without proper evaluation of that parents' role or responsibility. Dr. Miranda stated:

The case studies revealed there were multiple investigations determined unsubstantiated prior to the investigator gathering sufficient evidence, speaking to collaterals, contacting the reporting party, or conducting a thorough background and criminal history review. Future investigators and supervisors may underestimate the risk of abuse or neglect on the current investigation when reviewing an “unsubstantiated” referral history on a family. The investigator may conclude there were no concerns in previous investigations if they do not complete a thorough CYFD prior records review.

b. Unclear investigation policies

Unlike other states, CYFD does not have standard procedures for locating a child victim when initial contact efforts fail.³⁷⁹ Dr. Miranda also found that CYFD policies do not clearly define or direct what should be considered a “historical report” for the purpose of deciding whether to screen out a complaint from further investigation. A lack of consistent policy makes the screening process susceptible to variability and ad hoc decision-making.

c. Limited decision categories

CYFD's use of a binary investigation decision system—where investigations are either “substantiated” or “unsubstantiated”—fails to capture the complexity and nuance of cases, and may understate the degree of caregiver culpability. This framework does not account for the difference between cases where abuse or neglect allegations were truly unfounded, and cases where investigations were incomplete, obstructed, or lacked sufficient evidence. As a result, investigators often treat unsubstantiated findings as if the abuse or neglect did not occur, overlooking the fact that many such cases merely reflect inconclusive circumstances rather than confirmed innocence.

d. Lack of discretion for child removals

CYFD's policy for temporary removal of children facing imminent harm is more cumbersome and bureaucratic than other states. It requires more levels of supervisory approval and legal staffing than other states, which tends to delay urgent protective action.

e. Poor documentation

Many CYFD records were missing crucial information about families, impeding the work of investigators.

³⁷⁹ CYFD policy simply provides that efforts to locate a child and family must continue until contact is made or deemed futile by the county office manager. CYFD Invest. Proc. PR 10, § 6 (“Efforts to Locate the Child and Family”). By contrast, Arizona requires caseworkers to make at least three attempts on different days and at different times of the day to locate the child victim and family. Ariz. Dep't of Child Safety, [Practical Guidelines: Reasonable Efforts to Locate in Investigation Cases](#) 1 (Aug. 27, 2020). California and Utah utilize a protective custody warrant process for at-risk children that cannot be located. Cal. Fam. Code § 3134.5; Utah Code Ann. § 80-2a-303(1)(b).

f. *Insufficient consideration of aggravated circumstances*

When assessing child safety, CYFD investigators often failed to consider aggravated circumstances, such as prior substantiated abuse, failed reunifications, or terminated parental rights of other children. As a result, children were sometimes left in unsafe conditions despite clear histories that should have triggered stronger protective action or fewer attempts at reunification.

g. *Untimely case closures*

Investigations were often closed well past the 45-day deadline under policy. Untimely closures inflate caseload numbers and prolong investigations. These delays often leave children exposed to ongoing risk and burden families with prolonged uncertainty.

h. *Inadequate supervisory oversight*

Investigations consistently lacked appropriate supervisory oversight. This resulted in missed danger indicators, expired safety plans, and failure to initiate legal action despite credible risk to children. Supervisors did not correct incomplete or inaccurate assessments and failed to timely consult with investigators.

2. Errors in safety and risk assessments.

Structured Decision-Making (SDM) tools are designed to provide investigators with an objective and evidence-based framework to guide decisions. CYFD utilizes two related SDM tools—the safety assessment and the risk assessment. Dr. Miranda concluded that CYFD does not adequately train investigators to use these tools. In the cases she reviewed, investigators often struggled to recognize what facts and circumstances corresponded to different SDM categories. In some instances, Dr. Miranda noted that “[t]here was an overreliance on the parent’s interview responses without verifying the information through other sources such as collateral interviews, medical records, school records, and background checks on primary or secondary caretakers.” In other words, CYFD often took neglectful or abusive parents at their word without investigating further. Proper use of SDM tools can help prevent this.

In several cases, safety assessments had complicating factors that were not sufficiently documented, such as substance abuse, mental health issues, domestic violence, or developmental/cognitive impairments. The factors should have made it apparent to investigators that parents were unable to meaningfully engage in safety planning. Investigators also often overlooked children’s vulnerabilities and underutilized discretionary overrides, resulting in risk assessments that failed to fully reflect the severity

of threats to children. Finally, SDM tools were used as a substitute for professional judgment and critical analysis, rather than as a supportive guide to inform it. Dr. Miranda opined:

Another theme that emerged in this analysis was an overreliance on the SDM tools as the final decision-maker. If the safety assessment indicated the family was safe, then the investigator took no further action despite other evidence indicating the child's safety might be in danger. There was minimal to no intervention on some investigations where there were clear and present danger indicators. Danger indicators were entirely missed or listed as complicating factors without full consideration of the applicable safety threats to the child or the lack of parent's protective capacities. The override and other options in SDM were not utilized.

3. Safety concerns of substance-exposed CARA infants.

Dr. Miranda expressed concern that CYFD has increasingly declined to investigate referrals involving substance-exposed infants since New Mexico enacted its CARA law in 2019.³⁸⁰ As of 2023, the rate that CYFD “screens out” those abuse and neglect referrals is more than double the national average, likely due to other states applying broader risk criteria to initiate investigations. The recent decline in investigations coincides with rising child fatalities across New Mexico, suggesting that CYFD is merely substituting CARA plans for necessary investigations.

Even when CYFD does investigate cases of substance-exposed infants, it often fails to conduct thorough assessments. Dr. Miranda found that investigators are not consistently using all available tools—such as public health nurse consultations, medical record reviews, or SDM override options—to capture the full scope of risk. Critical factors like parental capacity, home environment, and signs of withdrawal or developmental complications are frequently overlooked. Superficial investigations result in lost or delayed opportunities for early protective action.

4. Ineffective use of safety plans.

CYFD's safety plans too often amount to mere promises on paper without providing any real protection for children. Dr. Miranda found safety plans were often incomplete, inappropriate based on the circumstances, inadequately monitored, and seldom enforced when violations occurred. Investigators also routinely failed to address critical issues such as visitation, education, and medical consent. According to Dr. Miranda, safety plans alone do not mitigate household threats. Supportive services—such as counseling, substance

³⁸⁰ These screened-out investigations include referrals based on broader indicators of abuse or neglect. Evidence of drug use or abuse, without more, does not meet the legal threshold for abuse or neglect under NMSA 1978, Section 32A-4-3(G).

abuse treatment, and parenting classes—are essential supplements to safety plans but are often refused or not offered.

Dr. Miranda also noted that safety plans and monitors were often inadequate to protect infants when a caregiver had an active, untreated substance use disorder. Unlike many other states, CYFD frequently leaves children in the home even when a parent is actively struggling with substance abuse. In those cases, CYFD also failed to ensure that parents were actually receiving the treatment necessary to keep their children safe. As a result, children remained in environments where preventable abuse and neglect continued.

5. Challenges in workforce recruitment and retention.

Dr. Miranda concluded that high employee turnover is a key driver of CYFD’s problems—a trend that has worsened between 2024 and 2025. While attrition stems from various factors, a major cause is a lack of perceived support from Department leadership. Instead of addressing CYFD’s negative organizational culture to improve employee retention and job satisfaction, the Department has lowered educational and hiring standards to expand its applicant pool. This approach risks de-professionalizing the child welfare workforce and worsening outcomes for children and families. Dr. Miranda points out that other states require higher employee qualifications, requiring licensed social workers for certain positions.³⁸¹

Dr. Miranda further observed that CYFD staff and management may lack sufficient training on the *ex parte* process for removing children from unsafe environments. This knowledge gap may stem from CYFD’s comparatively brief training program—which consists of five weeks of New Employee Training followed by on-the-job learning. In contrast, other states provide two to four months of classroom or hybrid training. For example, California offers a multi-month curriculum, and new employees in Arizona attend a 22-week academy. Dr. Miranda recommends that New Mexico consider similar training, and adopt innovative methods to prepare incoming caseworkers, such as simulation labs, virtual reality, role-playing, and structured shadowing.

Dr. Miranda’s full report—*Prioritizing Child Safety: Recommendations to Strengthen New Mexico’s CYFD Protective Services Division*—is available [here](#).

³⁸¹ For example, California requires emergency response/investigations supervisors to have master’s level social work degrees. Cal. Code Regs. tit. 22, § 86065.2(b).

V. RECOMMENDATIONS

As part of its investigation, the NMDNJ gathered recommendations from a diverse coalition of stakeholders—former CYFD staff, social work professors, youth attorneys and GALs, *Kevin S. plaintiffs*, foster parents, law enforcement, medical professionals, service providers, and practitioners from other states. While many of CYFD’s persistent failures stem from noncompliance with existing policies, stakeholders also identified broader opportunities to strengthen departmental practices and the wider child welfare system. To address the systemic breakdowns undermining CYFD’s mandate, the following non-exhaustive list of recommendations warrants further consideration by CYFD leadership and policymakers:

→ **1. Building a Skilled & Supported Workforce**

- 1.1 – Pursue surge hiring of mission-critical staff—including investigators, PPWs, and Children’s Court attorneys—and accelerate recruitment and onboarding.
- 1.2 – Prioritize recruitment of social workers, establish pathways for existing staff to earn BSW/MSW degrees, and require (at a minimum) that supervisors, county office managers, and other investigations and permanency decision-makers maintain social work licensure.
- 1.3 – Strengthen partnerships with higher education institutions to support internship-to-employment pipelines for social work graduates.
- 1.4 – Implement a comprehensive retention and wellness program that pairs new hires with robust supports—such as peer buddy systems and experienced mentors—alongside accessible counseling for vicarious trauma and mental health. Leverage workforce assessment tools like the Comprehensive Organizational Health Assessment to identify root causes of turnover and shape employee development strategies.
- 1.5 – Tailor separate training tracks for new investigations, permanency, and licensing and support staff to enhance role clarity and competency.
- 1.6 – Implement mandatory, periodic training for investigators and PPWs, and leadership programs for incoming supervisors, targeted to address past performance gaps.
- 1.7 – Child Welfare Expert Recommendations: [Dr. Mayola Miranda’s Recommendations for Advancing the Workforce](#).

→ **2. *Strengthening Abuse & Neglect Investigations***

- 2.1 – Improve investigations by adopting trauma-informed interviewing practices, corroborating witness accounts, leveraging law enforcement expertise, conducting unannounced home visits, and engaging in broader assessments of potential risks to children.
- 2.2 – Revise investigation finding options by adding a third, “inconclusive” category, prohibit case closures as “unsubstantiated” due to family inaccessibility or non-engagement, and apply consistent standards for investigation substantiation.
- 2.3 – Mandate supervisory compliance with pre-initiation and closure staffings, including escalation to COMs for repeat abuse or neglect reports. Require a critical analysis of safety and risk assessments, confirm service referrals and engagement, and consider alternative interventions if parental participation in services is lacking.
- 2.4 – Create a dedicated team within PSD to investigate fatalities and other critical incidents of children in state custody, with investigative findings provided to the CYFD Secretary and the Office of the Child Advocate.
- 2.5 – Compel CYFD to notify law enforcement upon release of a 72-hour hold, and expand information-sharing practices to support swift welfare checks and facilitate criminal investigations. Explore ways to improve CYFD–law enforcement collaboration, such as co-locating investigators with detectives and/or encouraging joint field experiences to build trust.
- 2.6 – Child Welfare Expert Recommendations: [Dr. Mayola Miranda’s Recommendations for Improving Investigations.](#)

→ **3. *Evaluating Child Safety & Developing Safety Plans***

- 3.1 – Retrain investigators and PPWs on proper use of SDM tools and override criteria, stressing that tools are guidance—not rigid rules—and that professional judgment and common sense must drive final decisions.
- 3.2 – Enforce the policy requiring completion of safety and risk assessments before child reunification, and mandate COM-level (or higher) review and approval of all assessment findings.
- 3.3 – Require that every safety plan is:

- a. *Clear and specific*—outline all responsibilities for both families and designated safety monitors;
 - b. *Comprehensive*—address all identified safety threats and include provisions for key areas of the child’s daily life during pendency of the plan, such as education and medical decision-making;
 - c. *Explicit on consequences*—define immediate responses for violations, including filing custody petitions. Prohibit use of safety plans as a means to sidestep necessary child removal from abusive or neglectful environments;
 - d. *Actively monitored*—assign a dedicated staff member with a set monitoring schedule to conduct in-home visits without exception, and report immediately to law enforcement if contact is lost; and
 - e. *Closed only when safety is assured*—before plan expiration, complete new assessments and either close upon fully mitigating danger indicators or initiate additional interventions.
- 3.4 – Establish policy criteria for selecting safety monitors, requiring clear role expectations and rigorous background checks. Prohibit monitors with conflicts of interest, substance abuse issues, or close ties to biological parents, including anyone who previously failed to report abuse or neglect or resides in the home where it occurred.
 - 3.5 – Child Welfare Expert Recommendations: [Dr. Mayola Miranda Recommendations for Improving Safety and Risk Assessments](#) and [Dr. Mayola Miranda Recommendations for the Effective Use of Safety Plans](#).

→ **4. Child-Centered Services & Permanency Practices**

- 4.1 – Treat foster families as essential partners by offering ongoing mental and emotional support, meaningful involvement in case planning, and clear communication channels with PPWs and supervisors.
- 4.2 – Ensure foster parents receive essential information prior to a child’s placement, including medical, behavioral, and educational details. Provide timely reimbursement and increased activity stipends to enable caregivers to meet basic needs and support extracurricular activities.
- 4.3 – Create a specialized CYFD team of clinicians to serve children with high needs, provide expert consultation on service recommendations to caseworkers,

and ensure access to neuropsychological and other evaluations to support eligibility for appropriate programming.

- 4.4 – Consider legislative changes to the Children’s Mental Health and Disabilities Code to either allow mandated psychological treatment more easily, or raise the age of refusal above 14.³⁸² Alternatively, create and fund youth services positions to ensure access to care for adolescents age 14 and older.
- 4.5 – Pursue court-ordered services when families refuse currently voluntary services and statutory criteria are met. CYFD should treat service referrals as essential to parental rehabilitation—not mere formalities—and seek custody when caregivers fail to engage with available resources and abusive or neglectful conditions persist.
- 4.6 – Require multidisciplinary consultation among permanency supervisors, clinicians, and attorneys—with documented approval by the CYFD cabinet secretary—before authorizing trial home visits and/or eventual reunification of a child with caregivers who have prior substantiated abuse or neglect reports, ensuring strict oversight and accountability.
- 4.7 – Reduce reliance on congregate care facilities and prioritize development and expansion of community-based behavioral health services—including high-fidelity wraparound services and intensive therapeutic supports—while prioritizing treatment foster care and foster parent recruitment and retention to ensure hard-to-place youth have family-based placements.
- 4.8 – Until the elimination of congregate care facilities:
 - a. Require more frequent surveys/inspections of such facilities;
 - b. Lower staff-to-child ratios;
 - c. Mandate that direct care staff have relevant child welfare experience or complete rigorous trauma-informed training; and

³⁸² New Mexico law allows youth who are 14 years or older to refuse psychological treatment, despite clear evidence that adolescent brains are not yet developed. NMSA 1978, § 32A-6A-15. This is inconsistent with other statutes, such as the Delinquency Act, which presumes that confessions of 13- and 14-year-olds are inadmissible in court because youth cannot knowingly waive their constitutional rights against self-incrimination. NMSA 1978, § 32A-2-14. It is incongruous that adolescents are fully permitted to make equally consequential treatment decisions.

- d. Support the Zero Suicide initiative³⁸³ under the state Behavioral Health Collaborative and integrate its suicide prevention and treatment protocols into residential and congregate settings.
- 4.9 – Mandate that LCA adopt and publish clear policies for abuse and neglect investigations in congregate care facilities. Require that all investigative outcomes be entered into the department-wide case management system, and establish a statewide tracking process to ensure individuals who have abused or neglected children cannot work in any licensed facility.
- 4.10 – Maintain children in their school of origin unless a change is clearly in their best interest, preserving educational continuity and support systems to minimize instability during time in foster care.
- 4.11 – Establish, through policy or statute, a mandatory adoption full-disclosure process to be completed within a defined timeframe, with enforceable consequences for noncompliance.

→ **5. Accountable Leadership and Organizational Reforms**

- 5.1 – Amend state law to require that CYFD’s cabinet secretary possess professional child welfare experience.
- 5.2 – Demand CYFD leadership complete recurring training in child welfare best practices and legal mandates, and cultivate a non-defensive culture where decisions prioritize improving outcomes for children over protecting institutional and personal reputations.
- 5.3 – Consider transferring licensing and certification authority for child-serving facilities from CYFD to DOH to eliminate incentives that prioritize placement availability over safety and quality in licensing decisions.
- 5.4 – Require CYFD’s Office of Constituent Affairs and Office of Advocacy to share all external complaints with the Office of the Child Advocate (OCA),³⁸⁴ and

³⁸³ Education Development Center, [Zero Suicide Initiative](#) (last visited Jan. 31, 2026).

³⁸⁴ The Office of the Child Advocate, which is administratively housed within the NMDOJ, was established by the Legislature in 2025 to provide oversight of New Mexico’s child welfare system. See H.B. 5, 57th Leg., 1st Sess. (N.M. 2025). Duties and responsibilities of the OCA include: (1) operation of a toll-free hotline and online portal to receive complaints; (2) investigation of complaints made by or on behalf of a child; (3) review of CYFD services and policies; and (4) monitoring and implementation of state and federal laws and regulations concerning children and families. NMSA 1978, § 32A-30-6.

designate the OCA as an appellate option for complaints unresolved through CYFD's internal processes.

- 5.5 – Implement youth advisory panels and foster care exit surveys to gather feedback on CYFD performance, require publication of findings, and incorporate results into policy development.
- 5.6 – Seek to restore public confidence through meaningful accountability practices, including the following:
 - a. Implementing a zero-tolerance policy prohibiting intentional misrepresentations in court proceedings or in communications with families and children;
 - b. Mandating that all court reports and testimony in permanency proceedings be made under oath, subject to perjury penalties for material, intentional misstatements; and
 - c. Enforcing a strict prohibition on retaliation by CYFD employees, with consistent application and serious employment consequences upon any violation.
- 5.7 – Institutionalize transparency through the following:
 - a. Amending state law to limit courts' authority to sequester hearings or restrict the release of information, except when necessary to protect narrowly defined personal identifying details or in truly exceptional circumstances;
 - b. Guaranteeing participation in individualized planning/family centered meetings and court proceedings for every member of the child's care team, including foster parents, therapists, educators, tribal representatives, and other essential stakeholders; and
 - c. Committing to prompt, accurate disclosures to oversight authorities and release of non-confidential records to the press and the public, while avoiding overreliance on confidentiality protections and providing the maximum information permissible under state law.

VI. CONCLUSION

The NMDOJ's investigation points unmistakably to one conclusion: CYFD has wholly abandoned child safety as its guiding principle. The witnesses interviewed and case studies highlighted show the grave harm that can result when CYFD delays removing vulnerable children from dangerous environments or reunifies them with families before underlying safety threats are resolved. Reunification should be the goal, but only when caregivers have meaningfully addressed the conditions that led to removal. A more deliberate child-centered approach is essential to ensure that reunification supports—not undermines—long-term family stability and child well-being.

CYFD has fallen short in multiple other respects, including tolerating weak leadership; avoiding transparency and accountability; shifting away from hiring licensed social workers, yielding a poorly trained and unsupervised workforce buckling under high caseloads; performing flawed investigations and superficial safety plans; permitting chronic permanency delays; failing to protect drug-exposed infants; disregarding law enforcement warnings and protective hold requests; eroding partnerships with foster families; allowing placement instability to worsen; and relying on office stays and expanded congregate care facilities that subject children to physical violence, sexual assaults, and ongoing trauma.

The NMDOJ expects this report to serve as the foundational roadmap guiding the incoming state child advocate's work. Central to their success is unfettered access to the records required to evaluate CYFD's decisions and practices. Yet the NMDOJ's investigation has shown that CYFD regularly resists such cooperation, even when the law plainly requires it. If the child advocate encounters this familiar resistance, policymakers should respond promptly and decisively to compel the Department's compliance. OCA must not be reduced to a symbolic role whereby it is presented as the face of CYFD's oversight but denied the levers of action to effectuate it. Equally important, the child advocate must neither rubber-stamp CYFD's actions nor excuse or rationalize its misconduct, but instead serve as an unapologetic champion for children's safety and well-being. Transparency and accountability can no longer be optional.

The NMDOJ shares the community's fatigue. Each child's death triggers public outrage and official condolences, but the cycle repeats as CYFD settles back into an equilibrium of stagnation and complacency, and avoids an honest reckoning with the policies, practices, and culture that contributed to the harm. Without a fundamental realignment to force CYFD to honor its child-safety mandate, more children will be abused, neglected, and killed. The tragedies highlighted in this report—and the many others not included but no less devastating—cannot be characterized as unexpected or without

warning. They are the predictable consequence of an institution that has repeatedly chosen self-protection over child protection.

APPENDIX A: ACRONYMS & ABBREVIATIONS

AG	Attorney General
APD	Albuquerque Police Department
APS	Albuquerque Public Schools
BCBS	Blue Cross Blue Shield
BCSO	Bernalillo County Sheriff's Office
BHU	Behavioral Health Unit (of BCSO)
CACU	Crimes Against Children Unit (of APD)
CANS	Child and Adolescent Needs and Strengths assessment
CAP	corrective action plan
CARA	Comprehensive Addiction and Recovery Act
CART	Child Abuse Response Team (through UNMH)
CASA	court-appointed special advocate
CBT	cognitive behavioral therapy
CCA	Children's Court attorney
CFSR	Children and Family Services Review
COM	county office manager
CPD	Clovis Police Department
CPS	Child Protective Services
CYFD	Children, Youth and Families Department
DCAP	directed corrective action plan
Department	Children, Youth and Families Department (unless otherwise specified)
DOH	New Mexico Department of Health
ECECD	Early Childhood Education and Care Department
EMS	emergency medical services
FACTS	Family Automated Client Tracking System
FCM	Family Centered Meeting
FFT	functional family therapy
FINCOS	Family In-Need of Court-Ordered Services Act
FOB	father of baby
FSD	Family Services Division (of CYFD)
FY	fiscal year
GAL	guardian ad litem
GCSO	Grant County Sheriff's Office
HIPAA	Health Insurance Portability and Accountability Act
HCA	New Mexico Healthcare Authority

HSD	New Mexico Human Services Department
ICWA	Indian Child Welfare Act
IEP	individualized education program
IHS	In-Home Services (of CYFD)
ILPS	independent living placement status
IPP	Individualized Planning meeting
IPRA	Inspection of Public Records Act
<i>Kevin S.</i>	<i>Kevin S., et al. v. Blaklock, et al.</i> , No. 1:18-cv-00896 (D.N.M. Mar. 26, 2020)
LBSW	licensed baccalaureate social worker
LCA	Licensing and Certification Authority (of CYFD)
LCSW	licensed clinical social worker
LFC	Legislative Finance Committee
LISW	licensed independent social worker
LMSW	licensed master social worker
MCO	managed care organization
MOB	mother of baby
MST	multi-systemic therapy
NAS	neonatal abstinence syndrome
NICU	neonatal intensive care unit
NET	new employee training
NMAC	New Mexico Administrative Code
NMCA	New Mexico Court of Appeals
NMDOJ	New Mexico Department of Justice
NMSA	New Mexico Statutes Annotated
NMSC	New Mexico Supreme Court
NMSP	New Mexico State Police
OCA	Office of the Child Advocate
OCR	Office of Children's Rights
OMI	Office of the Medical Investigator
OSA	Office of the State Auditor
POSC	plan(s) of safe care
PPLA	planned permanent living arrangement
PPW	permanency planning worker
PSD	Protective Services Division (of CYFD)
RAFT	Resource and Adoptive Family Training
SCAC	Substitute Care Advisory Council
SCI	Statewide Central Intake (of CYFD)

SDM	Structured Decision-Making
SJCSO	San Juan County Sheriff's Office
SVU	Special Victims Unit (of BCSO)
TFC	treatment foster care
TO	targeted outcome
TSI	temporary salary increase
TPR	termination of parental rights
UNMH	University of New Mexico Hospital
USC	United States Code
YOB	year of birth

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