August 4, 2026

STATEMENT FROM THE BOARD OF SUPERVISORS

Sophia Mason was an 8-year-old girl who deserved protection and a full life. Instead, her life was cut short. We mourn with her grandmother and extended family for what could have been.

Since her passing, we learned, and as a community reckoned with, the fact that the systems in place designed to keep her safe were unsuccessful.

We, as your elected officials, have elevated the tragedy of Sophia's death and focused on it relentlessly. We demanded answers from our county staff. We also welcomed experts from the State to review our actions and provide guidance.

We have taken the opportunity to conduct extensive internal reviews on how we can prevent this from happening again. And we have sought to learn from this experience.

Today we are announcing a settlement that resolves the civil litigation. **While this legal resolution may bring a small measure of closure, our work serving the community continues.**

As part of our commitment to transparency, we ordered a comprehensive independent investigation of the entire Sophia Mason case and a report containing recommendations on the best practices for conducting child welfare investigations, including new policies and practices.

Today, we are also announcing the release of this independent comprehensive internal investigation.

With the civil and criminal cases resolved, we wanted to share this with you, the public, immediately. The report is being released in full, with only select names removed to respect privacy or to honor California employment regulations and agreements with our labor partners. The report will be posted with the Board's agenda online shortly.

The independent investigation presents a series of deficiencies in our agency's actions in this case that we must address. These included staff decisions and actions, inadequacies in supervision, and systemic faults.

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Importantly, the report also provides **25 specific recommendations in policy and procedures** designed to prevent this from happening again.

Today's two developments - the legal settlement and release of Alameda County's independent investigation - do not occur in a vacuum.

As a Board, we have increased our oversight of the work of the Alameda County Department of Children and Family Services, and its extended network. This rigor will continue, and we will hold leadership accountable.

Alameda County is already working in partnership with the State of California. We are implementing the findings of the State Auditor's 2025 report.

Representatives from the Alameda County's Department of Child and Family Services recently updated this Board that, **among the State's 15 recommendations, seven have been fully implemented by our staff, while the other 8 are in progress.**

Earlier this month, California DSS issued a Findings and Recommendations Report which identified many of the same challenges as the State Auditor and our independent investigation. Alameda County welcomes the support, monitoring, and technical assistance that CDSS will provide for system improvement.

Locally, in our monthly update from Alameda County Social Services Agency leaders, we learned that:

- **Staff Vacancies**, a key finding from the public scrutiny, **have been reduced** from 32.8% to 21.2%.
- Ensuring we have a robust and thoroughly **trained team** is a priority but also remains a statewide, even nationwide, challenge in delivering public social services.
- **Case backlog continues to decline** and has been reduced by 57% from a peak of 3,900 to about 1,500.

We honor that each of these cases represents the individual circumstances a child is facing, each equally as important as Sophia Mason, and each deserving of the best support our agencies can provide.

Critical work remains, but this momentum heartens us.

Finally, we recognize that Alameda County's Department of Children and Family Services has already implemented important changes. These include new policies and procedures to identify, assess, and address physical abuse injuries.

Alameda County's Social Services Agency has also expanded its ability to use an investigatory search warrant for a medical exam or interview to gain insights into protecting children.

Agency Leadership and staff have, and will, undergo extensive new training, be held to new documentation standards, and new accountability for oversight and accuracy in safety and risk assessments.

As leaders of Alameda County, we recognize the gravity of this moment.

We understand that Sophia Mason deserved support from the public resources allocated and designed to protect her.

We reaffirm our countywide commitment to protecting our children and advancing systemwide improvement.

May we all honor the memory and spirit of Sophia Mason through our actions. May we work to hold our community close and to see that each child in Alameda County can access their infinite potential.

Confidential

Ensuring the Safety of Children in Child Welfare Investigations

Lessons Learned from the Case Review of **Sophia Cassandra Mason**

Presented to:

The Honorable Board of Supervisors

County of Alameda

1221 Oak Street, Suite 536

Oakland, CA 94612

Presented by:

Miranda Counseling & Consulting, LCSW Inc.
2901 W. Coast Highway, Suite 200
Newport Beach, CA 92663

July 20, 2026

Executive Summary

On March 11, 2022, Merced Police Department responded to a missing juvenile report. Police officers found Sophia Cassandra Mason deceased in a bathtub at the mother's residence, which was shared with the mother's boyfriend. Sophia died at the age of eight years old. Her death was ruled a homicide.

This independent case review evaluated Alameda County Department of Children and Family Services (DCFS) responses to the suspected child abuse referrals concerning Sophia's well-being. The primary focus of the case review was on the time period from January 2021 through October 2021, the year prior to Sophia's death.

Primary Questions

Child welfare agencies are responsible for ensuring children's safety, well-being, and permanency. Each County in California maintains a 24-hour hotline to receive and document calls from the community about allegations of suspected abuse to children. An investigator is assigned to meet with the child and parent if the suspected abuse report meets the criteria for an in-person investigation. A timely, thorough, and accurate investigation is an essential step in ensuring a child is free from abuse or neglect.

> **Question 1.** *What were the strengths and weaknesses of the DCFS Emergency Response investigations?*

> **Question 2.** *Did DCFS act appropriately in their response and handling of the suspected child abuse or neglect referrals received on behalf of Sophia C. Mason?*

Background of the Sophia Mason Case

Alameda County DCFS received eight suspected child abuse referrals concerning Sophia between 2014 and 2021. DCFS received seven of the suspected abuse referrals in 2021, when Sophia was seven years old. The final and ninth referral was received in March 2022 after Sophia's deceased body was found in Merced, California.

DCFS conducted three in-person investigations involving the Johnson Mason family: one investigation in March 2014, one investigation from January-March 2021, and one investigation in October 2021.

The January 22, 2021, referral alleged general neglect and physical abuse to Sophia by the mother, Samantha Johnson. DCFS received an additional four referrals while the January 22, 2021, investigation was open. The subsequent referrals contained duplicative allegations to previous reports as well as new allegations of physical abuse. The new allegations of suspected abuse to Sophia included alleged physical injuries by the mother's boyfriend, Dhante "Dave" Jackson.

The referrals received by DCFS on February 2, 2021, two from February 11, 2021, and February 22, 2021, were evaluated out. Incorporating a referral into an open investigation means that the information received by the hotline does not rise to the level of child abuse or neglect or else the allegations have already been investigated and are duplicative in nature. These referrals are categorized as evaluated out and sent to the current CWW to include the information in the current investigation.

The evaluated out referrals were assigned to the current Emergency Response (ER) Child Welfare Worker (CWW) to incorporate the new concerns into the open investigation. Ultimately, the assigned CCW incorporated two of the evaluated referrals into the investigation: February 2, 2021, and February

22, 2021. The investigative narrative erroneously listed one of the incorporated referrals as February 11, 2021, instead of February 22, 2021.

DCFS received two of the incorporated referrals on February 11, 2021. The first referral received at 7:05 PM was categorized as an *Immediate* response by the hotline screener after utilizing the SDM tool for physical abuse. The referral contained allegations of suspected physical abuse to Sophia by the mother's boyfriend Dave aka Dhante Jackson. This was the first referral that listed Mr. Jackson as an alleged perpetrator of abuse to Sophia. An ER Intake supervisor later changed the referral from an *Immediate* response to *Evaluated Out (EO)*.

On February 11, 2021, at 11:45 PM, a second referral was received by DCFS. The second referral was evaluated out due to it having the similar allegations as the earlier referral. The assigned CWW investigator was informed of the February 11, 2021, referrals via email. The investigator later testified that they never received the February 11, 2021, that alleged suspected physical abuse to Sophia by Dave. As a result, there was not a separate investigation conducted for the February 11, 2021, allegations. DCFS saw Sophia and the mother on February 11, 2021. The investigation was officially closed on April 21, 2021.

DCFS received the next suspected child abuse referral on June 16, 2021. The referral alleged physical abuse to Sophia. The caller reported they observed Sophia on this date to have "marks on her arms from the wrist to the elbow" and three small quarter-sized circular marks. The caller noted that Sophia appeared nervous and afraid to talk. Dhante Jackson was listed as the mother's boyfriend under the parent/caretaker category of the CPS Intake form aka the blue sheet.

The hotline screener utilized the SDM hotline tool to assess the call. Under the physical abuse screening, the "caregiver action that likely caused or will cause injury" was marked as well as "there is prior history of physical abuse by this caregiver." It is unclear if the caregiver/alleged perpetrator was the mother or the mother's boyfriend. The rest of the SDM screening tool was left blank including that the child is vulnerable or fearful, the preliminary section where the screener notes if the referral is evaluated out, the screening decision, the cross-report section, any applicable overrides, and the response priority section. The SDM decision tree recommended to proceed with an in-person response within 24 hours.

The new allegations received on June 16, 2021, for suspected physical abuse to Sophia by the caregiver were not investigated. For unknown reasons, DCFS ultimately categorized the referral as allegations of general neglect in CWS/CMS instead of physical abuse. In future referrals, CWS/CMS referral history does not indicate that the June 16, 2021, referral was for suspected physical abuse to Sophia.

On September 30, 2021, a mandated reporter called the DCFS hotline to report suspected physical abuse to Sophia. This was the fourth and final suspected physical abuse referral received by the County of Alameda. The caller reported suspicious injuries on Sophia that did not appear consistent with the explanation given by the mother. DCFS investigated the allegations but did not review the medical chart, interview the physician, review evidence photographs, or interview collaterals. DCFS did not ensure that the ordered follow-up testing of a skeletal survey was completed for Sophia to identify any current or historical injuries. The allegation of physical abuse to Sophia was determined unfounded by the responding ER investigator.

On March 11, 2022, DCFS received the last and final referral for suspected child abuse to Sophia. The

referral was received post-mortem. Law enforcement officers found Sophia's decomposed body in the mother, Samantha Johnson, and the mother's boyfriend's residence in the City of Merced, California.

"Remember that protecting the child from future abuse and neglect takes precedence over all other considerations in this process." [1]

Summary of Key Findings

This review considered Sophia's statements, witness accounts, DCFS records, deposition testimony, medical records, photographs of injuries, police reports, and autopsy findings. Multiple red flags were either missed or not adequately addressed to mitigate the risk of abuse to Sophia. Key concerns included limited efforts to interview "Dave," also known as Dhante Jackson, as an alleged perpetrator; the failure to investigate at least one of the February 2021 referrals and the June 2021 referral; and broader gaps in assessing escalating safety threats to the child Sophia over the course of one year.

Structured Decision-Making (SDM)

Another key finding was that DCFS did not always complete Structured Decision-Making (SDM) assessments accurately or thoroughly. SDM is a standardized assessment tool designed to evaluate the likelihood of future maltreatment by weighing a range of evidence-based risk factors through an actuarial assessment. Once the DCFS worker inputs the family's data into the risk assessment, SDM assigns a future child maltreatment risk level of *low, moderate, high, or very high.* The SDM safety assessment indicates whether a child is safe in the caregiver's home, if a safety plan is required, and if a protective intervention is necessary. The SDM hotline tool assessment assists the screener in decision-making to determine if a suspected child abuse reports meets the criteria for an in-person investigation or should be evaluated out and/or cross-reported to law enforcement. Additionally, the SDM hotline tool assists the screener to decide on a response time (10-day response or Immediate Response) for in-person investigations.

The faulty SDM assessments affected the ability for DCFS to correctly identify safety threats to Sophia's well-being at both the hotline and investigation stages. Inaccurate or incomplete SDM entries affected DCFS's response decisions, protective interventions, and safety planning throughout the handling of the Johnson Mason case.

In all three DCFS investigations, the Johnson Mason family's SDM risk assessment consistently rated the family as having a *moderate* risk of future child maltreatment. A SDM moderate risk rating indicates that the family exhibited a cluster of documented risk factors—such as prior referrals, substance-use concerns, mental health history, and caregiver history of abuse as a child—that placed the family at a greater likelihood of re-referral or recurrent abuse than a family assessed as *low* risk, though not as elevated as families assessed at the *high* or *very high* risk level.

A moderate risk score does not automatically require DCFS to initiate a child removal, safety plan, or other protective interventions. Whereas a high or very high-risk level tends to activate a recommendation

[1] Quote from the County of Alameda Policy Emergency Response Investigation Steps

towards a child removal in cases where there is a substantiated finding of abuse or neglect. Rather, the SDM risk score must be considered alongside the specific facts of the case, including identified safety threats on the safety assessment, corroboration of allegations, whether there are substantiated findings, the parent's protective capacities, the parent's cooperation, the parent's willingness to participate in a safety plan, and whether the identified safety threats can be mitigated through protective interventions.

DCFS must evaluate case-specific circumstances and incorporate them into the overall risk analysis. A child removal may be the only protective intervention to ensure a child's safety even when a family is considered at *moderate* or *low* risk for future child maltreatment. A family assessed as *low* risk may still warrant a removal if there is Immediate danger. While a family assessed as *high* risk may not require a child removal if the allegations are unfounded, there are no active safety threats, or the identified threats can be effectively mitigated through a written safety plan.

Several factors contributed to the family's SDM *moderate* risk level rather than the higher risk categories:

- There were no prior child welfare cases such as family reunification or family maintenance.
- There were no prior substantiated physical abuse or neglect investigations involving the mother.
- Sophia was over the age of two. Children under age the age of two are typically at higher risk of caregiver abuse.
- Sophia was an only child. Families with multiple children tend to be at higher risk of repeated referrals. SDM scores families with more than four children are scored as higher risk.
- There was no criminal history or domestic violence reported to the investigator by the mother and by the hotline screener on some of the suspected child abuse referrals.
- DCFS investigators opined that the mother used appropriate discipline with her child Sophia.
- The number of total investigations was on the lower end with a total of three DCFS investigations, none with substantiated findings. The referrals categorized as evaluated out do not count as an investigation.

The presence of a secondary caregiver can also affect the results of the risk assessment. The risk score will increase if a secondary caregiver or parent substitute has a criminal history, prior child welfare involvement, unresolved substance-use issues, domestic violence, or untreated mental health concerns. In Sophia's case, the secondary caregiver was allegedly the mother's boyfriend, Dhante "Dave" Jackson. There were allegations that the mother's boyfriend and/or alleged pimp, Dave, dropped the mother off to "work" while Sophia remained in Mr. Jackson's care. Sophia's relatives corroborated the allegations that the mother had openly engaged in prostitution for many years. There was no documentation that DCFS specifically investigated the allegations of Sophia's exposure to the mother's alleged sex work or sexual activities with her boyfriend Mr. Jackson.

There were also allegations that "Dave" disciplined Sophia with a belt and belt buckle leaving injuries on Sophia. DCFS investigators did not interview Mr. Dhante "Dave" Jackson or conduct background checks. The investigator attempted to call Mr. Jackson twice on the same phone number provided to the CWW on February 1, 2021, reaching a disconnected number on both attempts. No other attempts were made to contact Mr. Jackson besides the two phone calls on February 19, 2021, and February 22, 2021. Other attempts could have included an unannounced home visit, attempts to obtain a different phone number through the mother or collaterals, conducting a CWS/CMS or background check to obtain a current contact number or address, and mailing a letter to the last known address.

Moreover, the mother was not interviewed about Mr. Jackson's role in Sophia's life, including his role with discipline and childcare. The investigator did not inquire about the nature of the mother's relationship with Dave, even after Sophia reported that she was living with the mother and her friend Dave. There was no inquiry into Dave's criminal history, domestic violence history, employment, child welfare history, other children, or substance use. The SDM risk level may have revealed a higher risk score if Mr. Jackson was assessed as a secondary caregiver and he had associated risk factors.

Key Practice Issues Identified

The case review of Sophia C. Mason found several practice weaknesses in DCFS's response to the 2021 referrals of suspected abuse. The issues below reflect recurring concerns that affected investigative quality, the accuracy of safety and risk assessments, and protective intervention decision-making.

The case review found deficiencies in the following principal areas:

- Insufficient Hotline, Intake, and Emergency Response supervisory review and oversight.
- Limited supervisory consultation during Emergency Response hotline calls and investigations.
- Incomplete or missing documentation in the Child Welfare Services/Case Management System (CWS/CMS), including documentation of changes in household composition, changes in the family's location or residence, and updates or input of contact information.
- Inaccurate, missing, or incomplete cross-reports to law enforcement as required by Penal Code 11166.
- Inadequate or missing communication with the reporting parties, collaterals, and medical personnel including the lack of review of Sophia's medical charts and photographs of suspicious injuries in October 2021.
- Incorrect or incomplete Structured Decision-Making (SDM) hotline tools, safety assessments, and risk assessments.
- Untimely referral investigation closure or else premature closure of an investigation.
- Failure to respond and investigate to all allegations of suspected child abuse or neglect including evaluating out referrals that qualified for an in-person DCFS investigation.
- Investigators not including supervisors or program managers in important case decisions and consultations including the downgrading of screened-in referrals.
- Overall, there was lack of thorough documentation of all the steps in the investigations, consultations with supervisors, if any, and the visual inspections of Sophia during investigations.

Taken together, these deficiencies show that DCFS missed critical opportunities to identify Sophia as a highly vulnerable child in need of a stronger protective intervention. The recommendations that follow are intended to address systemic gaps in the County of Alameda DCFS's practices and policies to strengthen future child welfare investigations for ensuring the safety of children.

Recommendations for Best Practices in Child Welfare Investigations

1.	Mandate that Emergency Response Unit (ERU) investigations include criminal background checks, Megan's Law searches, and child welfare history reviews for all household members.
2.	Develop a clear policy for visual inspections of children for investigations of suspected physical abuse, including the assignment of a same-gender investigator. The policy should outline alternative options when a same-gender investigator is unavailable. Alternative options may include the involvement of another DCFS employee, a school nurse, a public health nurse, medical exam, or law enforcement. The policy should set out procedures for obtaining a medical exam warrant when a parent refuses consent and there are concerns of current injuries on a child.
3.	Hire public health nurses to support and aid the Emergency Response Unit with investigations in the field for referrals that involve suspicious physical injuries, medical neglect, special medical needs children, and to review a child's medical records.
4.	Require DCFS investigations to include at least two collateral contacts—such as a relative, neighbor, teacher, or medical professional, to corroborate parental statements. Also, mandate CWW's interview the reporting party when the reporting party's identity is known.
5.	Implement a clear policy requiring investigators to photograph a child's injuries during DCFS investigations when the child presents with current or historical injuries, scars, or marks indicative of abuse. Train ERU investigators to document injuries by describing the location, size, shape, approximate age, texture, color, and any associated pain felt by the child. The policy should include special procedures for photographing injuries located on or near a child's private areas. Medical exams can be used for identifying injuries near a child's genital areas. A nurse, child abuse expert, or pediatrician should conduct medical exams for sensitive body areas. CWW's can visually inspect injuries on other parts of the body such as arms or legs.
6.	ERU investigators should have access to sufficient supplies to document injuries, including county-issued cell phones, digital cameras, and measuring tools. Additional suggested field tools include rulers, tape measures, and reference items to provide scale and color of the injuries. Consider mandating the use of body charts to document the exact location of observed injuries, bruises, burns, marks, or scars. Require that photographs and completed body charts are uploaded in the child's CWS/CMS record.
7.	Use law enforcement to conduct conjoint investigations involving physical abuse and sexual abuse. Train ER investigators to report suspected criminal conduct by calling the local police jurisdiction while the CWW is at the family's home to allow for a conjoint investigation.
8.	At present, Alameda County DCFS mandates forensic interviews for sexual abuse investigations only and allows interviews for physical abuse investigations. Expand the use of CALICO forensic interviews to include physical abuse investigations on a case-by-case basis. Forensic interviews can be particularly helpful where there is no clear disclosure of abuse, yet suspicious injuries are present. Forensic interviews are helpful when there are conflicting statements about the cause of the injury, when law enforcement is involved to pursue a criminal complaint, or when there are concerns that a child may have been coached in their responses to DCFS.
9.	Provide refresher policy training for ER investigators related to confidentiality, HIPAA compliance, collateral interviewing, mandatory duties, case documentation, applying the specific facts of the case to SDM criteria, and the review of medical records.

10.	Train investigators to recognize red flags and other risk factors that increase the likelihood of future maltreatment. Incorporate the indicators into the SDM safety and risk assessments.
11.	Provide field access to web-based SDM tools to allow investigators to complete safety and risk assessments during in-person visits. Real-time SDM access can help investigators assess safety threats, determine risk levels, and decide whether a safety plan or other protective action are needed before leaving the family's home.
12.	Provide ongoing in-service training to strengthen investigator's child interviewing skills. Incorporate Safety Organized Practice or similar techniques that emphasize open-ended, child-friendly questions during investigations.
13.	Ensure that ER supervisors regularly use SafeMeasures to monitor investigation timeliness, response compliance, home visits, and contacts with the parents and children.
14.	Require hotline supervisors to conduct quality-assurance tasks including random audits of screening decisions, reviewing recorded calls, and ensuring the accuracy of the SDM hotline tool.
15.	Reduce staff-to-supervisor ratios to allow ER supervisors sufficient time for staff consultation, staff training, regular supervision meetings, timely referral closure, random quality control audits including contacting clients for feedback on the investigation. Supervisors should review case documentation to ensure policy compliance prior to approving a case for closure.
16.	Develop training on disproportionality, cultural humility, working with families of color, and the identification of injuries, marks, and bruises on children with darker skin tones.
17.	Use cultural brokers during investigations to support trust building and promote culturally responsive engagement with families whose culture or language differs from that of the CWW.
18.	Consider utilizing peer supervisor or program managers for secondary case audits of referrals that are evaluated out, designated as duplicates, or have a downgraded response.
19.	Encourage consultation with County Counsel and Program Managers on complex investigations.
20.	Require investigators to document in the investigative narratives and in CWS/CMS whether the child was interviewed in private or if there were any other adults present. If the child was not interviewed in private, the investigator should document the rationale.
21.	Standardize a practice to include a truth-versus-lie assessment for children during ER investigations, when age appropriate, and document in the investigation and CWS/CMS.
22.	Ensure that a family's current physical location is entered into CWS/CMS within 24 hours of receiving the new location information. Accurate information on a family's location is crucial for DCFS and law enforcement to be able to check on a child's safety, as well as proper cross-reporting to the correct law enforcement jurisdiction.
23.	Ensure that the hotline screeners are trained in SDM, enter an accurate summary of DCFS history, criminal history, and any known domestic violence history on the screener narrative. Screeners should be trained to elicit collateral information from callers to input on the referral.
24.	Increase public transparency by providing online access to DCFS policies, procedures, and organizational chart on the public facing County of Alameda DCFS website.
25.	Develop a communication protocol to inform Program Managers of downgraded referrals needing review. Ensure there is documentation of the approval and rationale to Evaluated Out or downgrade referral on the Intake face sheet (blue sheet) and on the screener narrative.

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Purpose of Case Review

The following investigative report examines the referrals, Alameda County DCFS investigations, and decision-making that preceded Sophia's death. The main body of this report provides details about the suspected child abuse referrals, the child welfare investigations, and DCFS's corresponding responses.

On or about March 8, 2022, the maternal aunt, [redacted], contacted Hayward Police Department to report that eight-year-old Sophia Cassandra Mason was missing after the mother told relatives that she had given Sophia away. The following is an excerpt from the Hayward police report:

> The reporting party stated she is the sister of the missing child's mom, Samantha Johnson. Samantha told family members she "gave her away" and refused to allow the family members any contact. No one in the family has seen the child since September 2021. The reporting party told Hayward Police Department officers she was concerned for her niece is because she had "genital bruising" and appeared to be thinner than the last time she saw Sophia.

On March 11, 2022, Merced Police Department officers discovered the decomposing body of Sophia in the downstairs bathroom of the mother and her boyfriend, Dhante Jackson's, residence. Sophia's body was located in the city of Merced, California approximately 100 miles from where the County of Alameda DCFS had last investigated the family in October 2021. Prior to her death, Sophia experienced neglect, physical abuse, and sexual abuse. Sophia was forced to sleep in a locked shed with a padlock in the backyard with limited access to fresh food or a clean bed for an unknown amount of time prior to her death. The following is an excerpt from Merced Police Department Crime Report.

> JOHNSON informed Det [redacted] that JACKSON had disciplined on the evening of February 10, 2022. then both of them went to bed and then the next morning they were unable to locate minor inside of the residence.
>
> JOHNSON began by stating that the night in question her daughter, minor was kept in the shed in the backyard. During the execution of the search warrant of the residence I saw a metal shed located in the southwest corner of the backyard. The shed faced in an easternly direction. There were several items of interest located in the shed.
>
> JOHNSON stated that there are bruises and belt marks on minor and that was inflicted on minor by JACKSON. I asked JOHNSON if she gave JACKSON permission to discipline minor and she said that she did.
>
> JOHNSON stated that she did not stop the discipline being inflicted by JACKSON due to the fact that she was, "In fear." JOHNSON went on to say that the fear was that she did not know how JACKSON would react if she told him to stop that type of discipline. JOHNSON also stated that she did not know what JACKSON would do to her if she told him to stop.
>
> JOHNSON admitted to disciplining her child, Mason, by, "whooping her." JOHNSON stated that she had never left any bruises or marks on her child when she disciplined Mason. JOHNSON then went on to state that one time she, JOHNSON, did, "choke her" (Mason). JOHNSON stated that she used one hand and placed it around Mason's neck. JOHNSON stated that when she put her hand around Mason's neck that she did not leave any marks.

Of note, from January 2021 to March 2021 the County of Alameda DCFS investigated a similar incident of choking to Sophia as described in the Merced police report. The DCFS investigation involved allegations of neglect, physical abuse to Sophia by the mother, Samantha Johnson. DCFS determined the allegations of physical abuse were inconclusive and the allegations of general neglect were unfounded.

On March 14, 2022, the Merced County Coroner's Office conducted an autopsy on Sophia's body to determine the cause of death, any pre-mortem abuse or trauma including sexual abuse. It is unknown the extent of the abuse Sophia experienced while alive. DCFS's investigation narratives did not document whether Sophia was interviewed regarding sexual abuse by anyone in the home including the mother's boyfriend. However, the mother told police that she believed the post-mortem medical exam would show that her daughter Sophia had been "raped." The mother stated that she saw a cell phone photo of Sophia orally copulating Mr. Jackson. The police ordered an autopsy of Sophia's body along with a sexual assault kit. There were limitations with the autopsy given the decomposing condition of Sophia's body.

In 2023, a Civil Case was filed against the County of Alameda by the Estate of Sophia C. Mason. Claims against the County of Alameda included allegations that DCFS failed to protect Sophia from severe abuse, neglect, death; violation of Child Abuse and Neglect Reporting Act (CANRA); and alleged breach of mandatory duties.

Applicable Standards for Child Welfare

- Federal Statute: Child Abuse Prevention and Treatment Act (CAPTA), P.L. 93-247
- State Statutes: Mandatory reporting laws, Child Abuse and Neglect Reporting Act (CANRA) is a California law (Penal Code § 11164-11174.3); Welfare and Institutions Code (WIC)
- State Child Welfare Mandates: California Department of Social Services (CDSS), Division 31, Manual of Policies and Procedures (MPP) for 2016
- County of Alameda, DCFS Authorities and References for the Emergency Response Program
- County of Alameda's System Improvement Plan (SIP) for 2024- 2029

Documents Reviewed

- DCFS Discovery Case Records for Sophia Mason: Emergency Response Investigations, Hotline calls, Structured Decision-Making assessments, Case Notes, Correspondence
- Merced Police Report #2022-00014508, 3/11/2022, Supplemental Reports
- County of Alameda DCFS Emergency Response Policies
- Fresno State Antemortem Forensic Trauma Analysis, 5/24/2022
- Examiner: [redacted], Forensic Anthropologist, Case # FA22-0406
- Photographs of Sophia's injuries taken by Medical Provider, Clinical Chart Notes, 9/30/2021
- Media Articles on Sophia's Death, Various Dates and Sources
- Johnson Family's Memory Video of Sophia Shown at the Funeral
- Deposition of [redacted]
- Deposition of [redacted]
- Deposition of [redacted]
- Deposition of [redacted]
- Deposition of [redacted]
- Tort Claim, Estate of Sophia Mason v. County of Alameda, 9/12/2022, ID: 2022-000208
- Missing Juvenile Report, Hayward Police Department, Case # 2021-00004438, 1/26/2021

Chronology of Events

The timeframe for the case review was March 21, 2014 through March 11, 2022 with an emphasis on the 2021 suspected child abuse referrals. DCFS investigations were conducted in the cities of Hayward and San Leandro in Alameda County, California. A summary of the totality of the referrals received by the Alameda County DCFS hotline about the child, Sophia C. Mason, and the mother, Samantha Johnson aka Mason is outlined in *Table 1*.

Table 1. Summary of DCFS Referrals

Referral #	Date	Allegations/Alleged Perpetrator	Response Time	Findings
1.	3/21/2014	Severe Neglect/Mother	10-day Response	Unfounded
2.	1/22/2021	Physical Abuse/Mother General Neglect/Mother	Immediate Response	Inconclusive Unfounded
3.	2/2/2021	General Neglect/Mother	Evaluated Out	Incorporated into Open Investigation
4.	2/11/2021 (Call #1)	Physical Abuse/Dave General Neglect/Mother	Immediate Response; Downgraded to Evaluated Out	Not Investigated
5.	2/11/2021 (Call #2, same reporter)	Physical Abuse by an unknown male named Dave	Evaluated Out	Not Investigated
6.	2/22/2021	Physical Abuse/Unknown*	Evaluated Out	Incorporated into Open Investigation
7.	6/16/2021	General Neglect/Mother Physical Abuse/Unknown	Evaluated Out	Not Investigated
8.	9/30/2021	Physical Abuse/Unknown	Immediate	Unfounded
9.	3/11/2022	Severe Neglect (After Sophia was found deceased)	Evaluated Out	Investigated by Merced County

* Unknown indicates that there was no named alleged perpetrator listed on the child abuse referral.

FIRST DCFS INVESTIGATION

On March 21, 2014, the County of Alameda DCFS received the *first* referral of alleged child abuse report regarding Sophia, age 2 months. The caller alleged that the mother had a long history of using drugs and engaging in prostitution. The mother was living with Sophia's maternal grandmother at the time. The maternal grandmother was identified as a secondary caretaker and interviewed during the DCFS investigation. CWW [redacted] interviewed the mother and the maternal grandmother, [redacted] during the investigation. The maternal grandmother did not have any concerns about the mother's parenting. The investigating social worker observed the infant Sophia to be well cared for by her mother and

grandmother. DCFS closed the referral. The allegations of general neglect by the mother, Samantha Johnson aka Samantha Mason (DOB 12/8/1991) were Unfounded.

SECOND DCFS INVESTIGATION

After the first referral in 2014, the County of Alameda DCFS did not receive another suspected child abuse referral concerning Sophia for nearly seven years. On January 21, 2021, the mother took Sophia out of the relatives' home with the assistance of law enforcement. Sophia had been raised by her maternal grandmother, [redacted], in an informal kinship arrangement. Since there was no legal guardianship or court order in place, the mother was able to remove Sophia from the grandmother's home.

On January 22, 2021, DCFS received a call on the child abuse hotline reporting suspected child abuse to Sophia by the mother. The caller reported that the mother was observed hitting Sophia on the thigh. Also, Sophia disclosed that the mother "choked" her and covered her mouth so that relatives would not hear Sophia scream. Sophia was then scared to sleep in the same room as the mother. The caller also reported that the mother has psychiatric issues and has made threats to self-harm in the past but not recently.

The referral was assigned to Emergency Response Unit (ERU) Child Welfare Worker (CWW) [redacted] as an Immediate response. [redacted] conducted an unannounced home visit the same day, as required by State and County mandates. [redacted] initially met with Sophia and the mother at their hotel room where they were temporarily residing. [redacted] observed Sophia to be clean, wearing clean clothing, with sufficient basic needs.

On January 26, 2021, the maternal relative, [redacted], filed a missing juvenile report with the Hayward Police Department, Case #2021-00004438.

Sophia's Physical Abuse Disclosures

On January 22, 2021, [redacted] interviewed Sophia about the alleged physical abuse that the mother had "choked" Sophia. It is unclear from the case documentation if the mother was in the same room during Sophia's interview or left the hotel room to provide privacy for the interview. Sophia disclosed to [redacted] that her mother grabbed her by the neck but "it didn't hurt." The mother covered her mouth because Sophia was crying loudly. [redacted] testified in deposition that Sophia was able to show the force the mother used when grabbing Sophia's neck. [redacted] noted the mother did not restrict Sophia's breathing nor left injuries. [redacted] did not have concerns about Sophia's well-being or the mother's ability to parent Sophia during the first contact. Sophia reportedly felt safe in the mother's care. [redacted] noted that Sophia was "soft spoken with mildly delayed speech" and that Sophia had difficulty making "coherent sentences." [redacted] perceived Sophia as "credible and honest."

CWW [redacted] lost contact with the family after the initial visit. The mother told [redacted] that they would be moving to a women's shelter on January 23, 2021. The mother did not provide the address as requested by [redacted]. Several attempts to contact the mother were made by [redacted] from January 25, 2021 to February 3, 2021.It was later reported that the family had moved from the hotel to the mother's boyfriend's home who was allegedly also the mother's pimp.

On February 1, 2021, a relative contacted [redacted] with the mother's boyfriend's full name Dhante Jackson aka Dave, a phone number, the vehicle the Mr. Jackson drove, and an address where the mother may be staying in Hayward. [redacted] attempted to contact Mr. Jackson by phone twice but was unable to reach him due to a disconnected phone number. At her deposition, [redacted] stated she did not conduct any background

check or child welfare history for Mr. Jackson, as she did not believe there were any allegations directly involving him. Sophia's relatives had shared with [redacted] many concerns about Mr. Jackson including that he was physically harming Sophia.

CWW [redacted] saw Sophia one more time after the initial visit at the hotel. On February 11, 2021, [redacted] met with Sophia and the mother at a community park in Hayward. The maternal aunt, the mother's Regional Center case manager, and a police officer were also present. [redacted] testified that she had invited the officer to the visit in case Sophia had to be detained from the mother at the park. The case documentation shows that the police officer, Officer [redacted] was also there to follow up on a missing person report filed on the mother.

Officer [redacted] observed the mother as cooperative and not showing any signs of substance abuse or cognitive impairment that could be probable cause for law enforcement to detain Sophia from the mother. Officer [redacted] deferred to the social worker about the decision to remove Sophia from the mother's care for the allegations of abuse or neglect. It is important to note that law enforcement and DCFS have different standards and procedures for detaining a child from a parent.

At the park visit, Sophia told CWW [redacted] she was living with the mother and the mother's friend "Dave." According to the investigative narrative, [redacted] asked Sophia if she was being hit by the mother's "friends." The mother had previously told [redacted] they moved in with "friends." However, Sophia noted living with the mother and only one of the mother's friend, Dave. Sophia also disclosed to [redacted] that the mother hit her. When [redacted] asked Sophia why the mother hit her, Sophia responded that the mother wanted to "hurt her." Sophia also shared that she was scared of the mother. Reportedly, Sophia did not want to talk further and the interview ended.

[redacted] did not document any observed injuries or a visual inspection of Sophia to check for injuries. Sophia was not questioned on whether the mother had ever caused her marks, pain, redness, or injuries. The relative present at the park testified that Sophia told [redacted] that she was being hit with a belt buckle by the mother's boyfriend Dave. The relative further testified in deposition that she saw scabs, marks, and bruises in varying stages of healing on Sophia's knees and thighs at the park visit. Sophia reportedly partially pulled her pants down to allow [redacted] and the aunt to check for injuries. The relative noted that Sophia appeared upset and began "hyperventilating" at the park. [redacted] investigative narrative did not document that Sophia was hyperventilating during the interview. Nor did the investigator document that Sophia showed behavioral indicators of fear or that Sophia was checked for physical injuries or what marks may have been present.

The relative further testified that [redacted] walked away after observing Sophia and made a phone call to someone. When [redacted] returned, she told the relative "It's not enough to pull her." [redacted] investigative narrative and CMS/CWS case notes do not indicate there was a phone call. There was also no documentation about any supervisory consultation to discuss the possibility of placing Sophia in protective custody and/or filing a petition to start Court-ordered services. However, an internal email from the Intake Supervisor [redacted] to the hotline screener appears to indicate that the supervisor was at least aware of the interview at the park.

The mother left the park with Sophia to an unknown location without incident. This was the last interview and in-person visit with Sophia and the mother for the second DCFS investigation.

Subsequent Referrals

The County of Alameda DCFS received four new allegations of suspected child abuse while CWW [redacted] had an open investigation for the January 22, 2021 referral.

On February 2, 2021, DCFS received a *third* suspected child abuse referral alleging general neglect to Sophia. The caller reported the mother had absconded with Sophia. The caller was worried about Sophia's safety and noted that the mother may be prostituting herself in front of Sophia. Sophia had been out of school for two weeks at the time of the report. The caller shared concerns that the mother had rarely cared for Sophia, makes choices out of anger, and does not prioritize Sophia's well-being. [redacted] was notified of the new report to the hotline. The referral was Evaluated Out due to the duplicate allegations. Intake Supervisor [redacted] assigned the new referral to *incorporate* with the current open investigation. Incorporating the report means that the current CWW will address the new information in their current open investigation.

On February 3, 2021, the mother reported she and Sophia had moved in with friends. The mother said that the friends did not want DCFS involvement and she would meet [redacted] in a community setting. The mother did not offer her new address to DCFS. [redacted] did not request the new home address to schedule a home visit to check the conditions of the family's new home.

On February 11, 2021, at 7:05 PM, the County of Alameda DCFS received a *fourth* referral of suspected abuse alleging general neglect and physical abuse to Sophia by the mother's boyfriend Dave. The following is the screener's summary of the suspected child abuse call:

> It was reported that the mother's live-in boyfriend "beats" 7-year-old Sophia with a belt and the belt buckle and today Sophia has scabs on her shins and a bruise on her upper thigh that she said was from the belt and buckle. Sophia is very afraid of the mother's boyfriend and shook, hyperventilated, and cried today when she talked about him. The mother who is developmentally delayed, schizophrenic, and bipolar, is unable or unwilling to protect Sophia from Dave and the mother uses him to watch Sophia while the mother "prostitutes."
>
> Sophia might be at risk of physical harm if the mother's boyfriend, Dave, beats her with a belt and belt buckle and the mother does not protect Sophia. The next day, Sophia reported seeing Dave sucking on the mother's breasts. Sophia is residing with the mother and Dave sometimes. The mother was reported to be working as a prostitute on E. 14th Street. Dave drops the mother off at "work" and babysits Sophia while mom is working.
>
> Sophia told the mother's case manager today that "Dave beats me with a belt and a buckle." Sophia showed several scab marks on her shins and a bruise near her upper thigh near her pelvis. Sophia stated Dave hit her and her mother put cocoa butter on her injury.

The hotline screener assigned the new report as an Immediate response. The SDM hotline tool showed that the allegations met criteria for an in-person investigation. The hotline screener categorized the allegations as physical abuse, *non-accidental or a suspicious injury,* and general neglect/failure to protect. On the SDM decision tree, the hotline screener marked the following factors to inform the screening decision:

- Caregiver's behavior is alleged to be dangerous or threatening to child's health and safety.
- Child is vulnerable or fearful.
- There is prior history of physical abuse.
- Child is currently unsupervised and in need of supervision.

An Immediate response means that an in-person investigation must start within 2 hours per County policy or no later than 24 hours per State policy. DCFS Swing Shift Intake Supervisor [redacted] changed the referral from *Immediate* response to an *Evaluated Out*. On the CPS Intake Form/blue sheet, the Screener/SDM recommendation is listed as Immediate with a write in changing the response to EO. The refusal reason on the blue sheet was listed as "EO to incorporate" but no rationale was provided on the form. The SDM hotline tool with the decision tree recommended a response within 24 hours. There was a manual override written in for Evaluated Out /historical information only on the form.

On February 11, 2021, at 9:02 PM, Supervisor [redacted] sent an email to the hotline screener, [redacted], "[redacted] and PD was with MO (mother), the minor, the RP and were assessing for injuries. Officer and [redacted] did not observe any injuries, nor did they have enough to bring the child into custody. FYI. Everything that was reported, [redacted] was actively investigating this afternoon." Supervisor [redacted] sent an email to CWW [redacted] instructing her to incorporate the new allegations in the current investigation.

DCFS did not adhere to State and County policies when the referral was changed from an *Immediate* response to *Evaluated Out (EO)* without a program manager's approval. DCFS did not investigate the new allegations of suspected abuse to Sophia as required by State mandates.[2] Alameda County Policy instructs to obtain a program manger's approval if an override is used to Evaluate Out a referral. This policy applies to situations when an in-person response is recommended by SDM and the referral is subsequently changed to a lower response. If an override is used to increase the response to a higher level (i.e. from Evaluated Out to in-person response or from a 10-day response to an Immediate response), then only supervisory approval is required.

Supervisor [redacted] downgraded the referral of suspected physical abuse to Sophia believing that [redacted] had investigated the same allegations earlier that day. However, the subsequent referral contained new allegations of physical abuse by Dave, the mother's boyfriend. State policy requires that DCFS respond to all new allegations of suspected child abuse that meet the legal criteria of abuse or neglect.

The information was received *after* [redacted] had interviewed Sophia earlier that day. Therefore, the new information contained on the subsequent referral including that Dave had hit Sophia with a belt buckle and left marks were unknown to the investigator at the time of Sophia's interview. [redacted] investigative narrative shows that Sophia had told [redacted] she was living with the mother's friend Dave. Sophia also disclosed that one or more of the mother's friends was hitting her. There was no DCFS follow up to Sophia's disclosure of the mother's friend(s) Dave hitting Sophia with a belt and if Dave had ever left injuries or marks as a result of the hitting.

Supervisor [redacted] may have believed that law enforcement and/or [redacted] had sufficiently investigated the incident of alleged physical abuse when they met with Sophia. Nevertheless, the latest referral included further allegations of suspected abuse to Sophia that DCFS had not investigated before. The case documentation suggests that law enforcement's presence at the park was to keep the peace between the mother and aunt who had a contentious relationship. The mother told [redacted] she had filed a restraining order against her sister. Law enforcement was also following up on a missing person's report filed on the mother.

It does not appear that the officer was at the park visit to conduct an independent investigation of the alleged physical abuse to Sophia. The case notes do not show that Officer [redacted] visually observed Sophia for

[2] CDSS Div. 31-101.1 The County shall respond to all request for services which allege that a child is in danger by abuse, neglect or exploitation.

physical abuse injuries, observed [redacted] interview with Sophia about physical abuse, or individually interviewed Sophia as part of a police investigation for physical or sexual abuse.

On February 11, 2021, at 11:45 PM, the County of Alameda DCFS received a *fifth* referral alleging suspected child abuse to Sophia. The report was by the same caller that called in the earlier referral at 7:05 PM. This referral received was also evaluated out as the allegations were deemed duplicate to the earlier call.

On February 22, 2021, a mandated reporter called the DCFS hotline to make the *sixth* report of suspected physical abuse to Sophia. The mandated reporter relayed that a couple of weeks prior, a relative saw Sophia with five bruises on her arms, torso and one of her thighs. The relative believed Sophia's bruises were caused by the mother's "pimp." It was reported that Sophia was hysterically begging to live with the relative and the maternal grandmother. Per the SDM hotline screening tool, the hotline screener, [redacted] determined that the report was did not contain any new information. The referral was evaluated out with the rationale, "The allegations are duplicate in nature to referrals dated 2/2/21 and 2/11/21."

CWW [redacted] incorporated the referrals of February 2, 2021 and February 22, 2021 into her investigation. [redacted] stated in deposition testimony that she had concerns in her investigation about the family situation, but she had no concerns specifically about Sophia's safety. [redacted] did not observe Sophia to be fearful during the child interviews. [redacted] said she never received the new referral of February 11, 2021 that alleged physical abuse by Dave. As such, [redacted] did not have knowledge of the information contained within one or more of the February 2021 referrals. Therefore, [redacted] did not investigate all of the suspected child abuse allegations.

Contact with Collaterals

CWW [redacted] contacted several collaterals during her two-month investigation. On February 1, 2021, [redacted] interviewed Sophia's teacher who shared concerns about Sophia's speech abilities and lack of school attendance. The teacher was having Sophia assessed for a speech delay. Moreover, the teacher relayed doubt that Sophia had the ability to communicate if Sophia was "in danger." The teacher further shared that the mother appeared "unstable and scary."

[redacted] interviewed Sophia's maternal grandmother, [redacted]. There are no details in the CWS/CMS delivered service logs (case notes) elaborating the substance of the conversation with the grandmother or whether she shared any concerns over Sophia's safety in the mother's care. The grandmother did share that she was glad that DCFS was checking on Sopia.

[redacted] kept on-going contact with the maternal aunt, [redacted], throughout the investigation. The aunt provided information as to concerns over Sophia's well-being and information on Sophia's location. [redacted] invited the aunt to participate in a visit to check on Sophia's well-being on February 11, 2021.

[redacted] maintained ongoing communication with the mother's Regional Center case manager. The case manager opined that Sophia would be safer living with relatives. The case manager reported concerns that during a video call on February 8, 2021. The concerns Sophia presented wearing a hoodie that covered her body and head. Sophia appeared "nervous" and looked as if she was going to cry. On the same video call, the case manager saw the mother wearing a tank top while Sophia was covered up. The case manager shared her observations with [redacted] that "things did not appear right."

A child wearing clothing that covers the body and is inappropriate for the weather or conditions can be an important sign of abuse. Inappropriate clothing for the weather or baggy clothes may be a sign that a child is

hiding injuries. As such, an assessment for physical abuse including a visual inspection of the child should be conducted to evaluate if the child has injuries and assess if medical care is needed.

In Sophia's case, there had already been multiple allegations of physical abuse, a statement from Sophia that her mother had choked her, the mother tried to hurt her, and that the mother's friend(s) was hitting her. These factors taken together should have prompted a more thorough DCFS welfare check and home visit at the mother's new residence.

There are conflicting accounts between the relative's and [redacted] observation of Sophia's presenting injuries and behaviors. The relative reported she observed bruising and scabs on Sophia on February 11, 2021; while [redacted] did not document any marks or bruising. There was an no documentation of a visual inspection of Sophia to assess for physical abuse injuries. [redacted] along with the aunt conducted a brief body check for marks and bruises on Sophia. At deposition, [redacted] testified that Sophia pulled her pants down "to expose her sides" and Sophia's thighs were visible from the side. [redacted] further testified in deposition, "I didn't find any -- any bruising anywhere." The aunt testified that she pulled down Sophia's pants, pulled up her pants leg, lifted up Sophia's shirt. In contrast to [redacted] observations, the aunt reported she did observe marks on Sophia on February 11, 2021.

The mother's case manager kept on-going contact with [redacted] providing updates on the family. The case manager reported that she had been in contact with the family via Facetime and the family appeared good on March 22, 2021. The case manager informed [redacted] that the mother no longer wanted to work with her due to the case manager's communication with DCFS. As such, it was perceivable that Sophia would be even less visible to the community after the mother's case manager stopped contact with the family and the DCFS investigation closed.

On February 16, 2021, the mother sent CWW [redacted] a text that CPS was trying to "kill her." [redacted] email documents a forwarded text titled "Samantha Johnson":

"I'm not going over there Saturday cause i dont feel safe and i fear for my life and I know you don't care about my safety cause i told u about how my sister is so now I feel like cps is trying to kill me so ill be contacting ur supervisor and I will not talk to you anymore unless its with legal representation."

[redacted] appears to reference the mother's text messages and communication as evidence of "delusional thinking." The fact that the mother believed that DCFS and relative(s) were trying to kill her was not included in the investigative narrative. The mother's statements were not addressed in the investigative interviews, SDM assessments, supervisor consultation, or safety planning.

[redacted] did not contact the mother's mental health providers to investigation allegations that the mother's mental health may negatively impact the parenting of Sophia. Contacting the mother's providers should have included inquiring if the mother was engaged in treatment, whether the mother was medication compliance, and discuss any concerns of the mother's parenting abilities to safely parent Sophia. State and County policy requires that any person who could reasonably know about the allegations and the condition of the children must be interviewed as part of the investigation. [3] The mother's counselors, therapist, or any past or present substance treatment providers should have been contacted as collaterals.

[3] CDSS Div. 31-125 and Alameda County Emergency Response Policy

Missed Medical Visits

Officer [redacted] asked for CWW [redacted] to meet at Sophia's scheduled dental appointment on January 30, 2021. The mother and child did not attend the scheduled appointment. Sophia was scheduled for a pediatrician visit on February 22, 2021. Again, Sophia and the mother did not attend the appointment. Sophia was not seen by a medical provider until March 12, 2021, when she was seen by a pediatrician. Dr. [redacted] noted that Sophia had bruises on her knees. The doctor opined that the bruises could have been due to riding a bike and falling. There were no concerns of child abuse noted during the medical exam.

It is important to note that Dr. [redacted] medical exam of Sophia occurred four weeks after CWW [redacted] met with Sophia at the park on February 11, 2021. It is likely that any injuries Sophia may have had from January 2021 to March 2021 would have healed by the time Dr. [redacted] examined Sophia. The mother missing or delaying Sophia's medical and dental appointments should be included as an important part of the overall assessment.

Delays in seeking medical care for a child is important to note as a potential red flag to consider. Delays in medical care should be carefully evaluated in all suspected child abuse cases. In Sophia's case, there is the additional risk factors that she was not attending school where mandatory reporters are present and there were allegations of physical abuse. CWW [redacted] closed the DCFS investigation shortly after receiving Dr. [redacted] medical exam report on March 19, 2021.

Structured Decision-Making

CWW [redacted] completed a Structured Decision-Making (SDM) safety and risk assessment as required by policy. [redacted] did not identify any safety threats on the safety assessment. The completed risk assessment indicated that Sophia was at *Moderate Risk* for future caregiver maltreatment. [redacted] closed the investigation noting that the family's "Situation Stabilized." DCFS findings were Inconclusive for allegations of physical abuse and general neglect allegations were unfounded.

Although the DCFS investigator, [redacted] did not identify any safety threats for the January 22, 2021 and the subsequent referrals; this case reviewer opines that one or more of the following safety threats were present. SDM is a standardized and objective tool to guide decision-making by guiding the user through a series of yes and no questions for the safety assessment. Yet, there is still a great deal of professional judgement, training, and discretion required to effectively complete the SDM assessments.

Identifying a safety threat would have activated at a minimum a corresponding safety plan and a more robust protective intervention. DCFS protective interventions up to the possibility of placing Sophia into protective custody and filing a petition with the Juvenile Court.

Listed below are specific safety threats contained within the SDM safety assessment that could have been applicable in the investigation for the Johnson Mason family.

SDM Safety threat #1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation as indicated by serious injury or abuse to the child other than accidental, or caregiver fears he/she will maltreat the child, threat to cause harm or retaliate against the child, domestic violence likely to injure child, excessive discipline or physical force.

Example of applying the case facts to safety threat #1: The mother used excessive discipline and physical force when the mother "choked" Sophia and covered her mouth to prevent others from hearing Sophia crying

or screaming. This type of physical discipline had the potential of causing serious physical harm, injury, or death to Sophia. Moreover, Sophia reported fear of the mother after the choking incident.

SDM Safety threat #6. Caregiver is unable or unwilling to protect the child from serious harm or threatened harmed by others this may include physical abuse, sexual abuse, or neglect.

Example of applying the case facts to safety threat #6: The mother allowed her boyfriend, Dhante "Dave" Jackson, to physically discipline Sophia with a belt with the potential to cause serious harm.

SDM Safety threat #8. The family refuses access to the child, or there's reason to believe that the family is about to flee.

Example of applying the case facts to safety threat #8: The mother did not provide her current address or allow DCFS to visit the home once they left the hotel and moved in with the mother's boyfriend. During the investigation, the mother reported fear that DCFS was trying to kill her and that her relative was also trying to kill her. As such, the mother did not want to continue meeting with DCFS, would not accept DCFS services, did not want to continue meeting with the Regional Center case manager/payee, and did not allow relatives to see Sophia. Lastly, DCFS was unable to meet with Sophia on one or more occasions during the investigation due to the mother cancelling scheduled visits.

Complicating factors

SDM uses the term *complicating factors* for social workers to document conditions that make it more difficult or complicated to create safety for a child. Complicating factors are not automatically considered safety threats unless the complicating factor directly affects the caregiver's ability to safely parent the child. For example, a parent's substance use may impact their ability to supervise their child. For example, if a parent passes out due to inducing a substance and leaves their infant unattended.

Complicating factors can include substance use, mental health, domestic violence, homelessness, or developmental/cognitive impairments among others. CWW [redacted] identified the following complicating factors for the family in the investigative narrative:

- A maternal relative reports the mother has a developmental disorder that has impacted her ability to provide care for Sophia on her own.
- The mother has not been medication compliant for her mental health condition in years.
- Sophia was raised primarily by her maternal relatives and is now living with the mother.
- Samantha Johnson is homeless and resides with friends and in hotels.
- Sophia is isolated in the community and she is not attending school and does not visit her support network; the maternal grandmother and maternal aunt.
- Samantha Johnson appears to have delusional thoughts that her maternal sister is threatening her and wants to hurt her.
- Samantha Johnson reports she will decline to work with and receive services from the Regional Center due to feeling they are working with the agency.

Safety Plan

Written safety plans are needed when a safety threat is identified on the SDM safety assessment. CWW [redacted] did not note any safety threats on the SDM assessment. [redacted] developed a verbal safety plan with the mother for Sophia to visit with maternal relatives. The documentation does not clearly reflect how the

safety plan will mitigate risk or safety threats to Sophia. Moreover, the duration of the safety plan and whether someone from DCFS would monitor the safety plan was not in the documentation.

During the investigation, the mother told CWW [redacted] that she was not willing to allow physical contact between Sophia and the maternal relatives. The mother also relayed to [redacted] that the mother believed her sister was trying to kill her and take Sophia from her. The mother expressed she was applying for a restraining order against the maternal relative(s). As such, [redacted] should have concluded that the verbal safety plan would be ineffective.

Formal interventions must be considered when a parent is unwilling to cooperate with a safety plan to mitigate safety threats. At a minimum, there should be consultation with a supervisor to decide the next steps when there are still concerns for a family and/or the parent(s) indicate they will not voluntarily cooperate with services or a safety plan. There was no documentation to support there was supervisory consultation on the investigation or adequate safety planning to effectively address safety concerns.

A safety plan is discretionary if there are no safety threats identified during an investigation. Here, the safety plan did not address excessive corporal punishment, the mother's ability to protect Sophia from others, the mother's mental health, a childcare plan for when the mother worked, the mother's boyfriend's background or access to Sophia, or how Sophia would be more visible to the community.

Results of the Second Investigation

Sophia was seen twice in-person during the second DCFS investigation. Sophia was seen on January 22, 2021 at a hotel room and again at a community park on February 11, 2021. CWW [redacted] made brief phone contact with Sophia in March 2021. [redacted] was scheduled to meet with the mother, the mother's case manager, and Sophia on March 3, 2021. However, for unknown reasons the visit did not occur. There was no in-person contact with Sophia and the mother for the month of March 2021. State policy requires that children be seen monthly while there is DCFS involvement.

Of note, this investigation occurred during COVID-19 where there were limitations with in-person contact. Many children were in distance learning and not physically accessible at a school site. In addition, Sophia's mother did not ensure Sophia was attending school, online or in-person. Further complicating access to Sophia was the fact that the family moved and did not provide a current address nor was the mother consistently accessible by phone.

CWW [redacted] attempted to schedule a Child and Family Team Meeting (CFT) [4] to bring the relatives together and discuss a plan to keep Sophia safe, manage the conflict between the relatives, discuss the mother's mental health, concerns about the mother's boyfriend, and the physical abuse allegations. The mother refused to attend the meeting unless it was mandatory, Court-ordered, or there was a plan to remove Sophia from the mother's custody. DCFS did not mandate that the mother attend the CFT meeting and the meeting was subsequently cancelled.

[redacted] discussed a verbal safety plan with the mother to allow Sophia to have visits with relatives. The mother did not agree to the safety plan citing on-going conflict with relatives. The mother told [redacted] she would only agree to allow phone calls between Sophia and the relatives. Before closing the investigation, [redacted] offered the mother housing assistance which the mother refused.

[4] Children Family Team meeting (CFT), WIC 16501.1 (c)(d)

On March 21, 2021, [redacted] closed her investigation. The investigation was submitted to a supervisor for closure. On March 22, 2021, [redacted] submitted a cross-report to Hayward Police Department informing them of the suspected child abuse allegations to Sophia. However, the cross-report did not describe the incident information of the suspected abuse. Section 3 of the cross-report form was left blank instead of listing the specifics of the child abuse allegations including the child's statements or the details of the subsequent suspected abuse reports. A cross-report must contain details of the allegations for law enforcement to know what potential crime to investigate.

On April 21, 2021, a DCFS Intake supervisor approved the investigation closure. The investigation was open for 90 days. The State requirement is that investigations must be closed within 30 days. [redacted] completed the SDM assessments on time. However, SDM was not submitted to the supervisor until the investigation was closed, two months after initial contact with the family. [redacted] investigation disposition summary with rationale for closing the investigation without further protective interventions is provided below:

> The allegations of neglect by the mother, Ms. Johnson towards Sophia Mason is unfounded and the allegations of physical abuse by Ms. Johnson towards Sophia Mason is inconclusive. The minor, Sophia Mason, appeared to be cared for although the mother is transient. Sophia was observed to be well groomed and have appropriate clothing for the weather during both interviews with the minor. Sophia reported she had a bed to sleep in at night and enough food to eat.
>
> Based on the information obtained by the CWW during the investigation, there is no indication of physical abuse although Sophia disclosed her mother's friend was hitting her. Sophia could not give any additional information or details regarding the hitting. As a result, the allegation of physical abuse is deemed inconclusive. Sophia reported feeling safe with her mother on multiple occasions and was not observed to be fearful of her mother. The CWW completed a SDM safety/risk assessment. There were no safety threats present. The minor is a moderate risk for future abuse or neglect. This referral will be submitted for closure. Situation stabilized.

Deficiencies Identified in the Investigation

1. There was no CALICO forensic interview. CALICO is only required for sexual abuse disclosures investigations in Alameda County and is optional for physical abuse investigations. A CALICO forensic interview was a viable option to further explore possible physical abuse to Sophia, especially given Sophia's speech delay and reluctance to provide more information in the field interview. A forensic interview would have allowed DCFS to explore all types of abuse including following up on Sophia's disclosure about her mother's friend hitting Sophia, the mother's use of corporal punishment, the mother's ability to protect Sophia from abuse by others, and to explore Sophia's alleged exposure to sexual acts or sexual abuse. A forensic interview would have also provided a private child friendly space to engage with Sophia. The interview would ensure Sophia was interviewed away from outside influences including the mother, relatives, or others. Instead, [redacted] interviewed Sophia at the mother's hotel room and a community park. [redacted] noted that other adults were present at the park interview which may have influenced the child's disclosures.

2. CWW [redacted] investigation narrative reflected that Sophia was not interviewed extensively on a number of allegations including: follow-up on the disclosure of physical discipline "hitting" by the mother and the mother's friend(s), exposure to the mother's alleged involvement in prostitution, or any potential sexual abuse. If properly questioned, Sophia may have provided more information to inform the investigation.

Information elicited may have included he name of the mother's friend who was hitting her, whether the friend lived in the same house as Sophia, the friend's access to Sophia, the mechanism of hitting (such as whether Sophia was being hit with an object or hand), how often Sophia was hit (frequency), under what circumstances was Sophia being hit, and if the mother was willing to protect Sophia from physical harm.

3. [redacted] **did not adequately evaluate the mother's protective abilities to keep Sophia safe from the mother's** friend. Evaluating the mother's protective abilities is a principal requirement of an investigation. A thorough evaluation of a parent's willingness and ability is essential to accurately completing the SDM safety assessment, safety planning, and the risk assessment. A parent that is unable and/or unwilling to protect their child from the abuse of others qualifies as a safety threat on the SDM safety assessment. The inability to protect a child from abuse can be the result of fear of the perpetrator of abuse, domestic violence, or a parent's own mental health or substance use interfering with their protective abilities.

In March 2022, the mother told Merced police officers that she allowed her boyfriend, Dhante Jackson, to physically discipline Sophia (age 7 at the time) when they lived in the city of Hayward. The mother shared that she was afraid of Jackson due to domestic violence in the relationship. The mother further said she allowed Jackson to discipline Sophia because they lived in his house and that Jackson had previously left marks on Sophia.

4. The investigative narrative does not reflect that CWW [redacted] **questioned the mother about Sophia's** disclosure of corporal punishment from the mother's friend(s) including the allegation that Dave hit Sophia with a belt buckle. It was important for DCFS to assess whether the mother was aware of the hitting/physical abuse by Dave and assess if the mother was willing or able to protect Sophia. It was crucial for DCFS to assess the mother's friend's access to Sophia, whether the friend(s) were used as a childcare provider/secondary caregiver or parent substitute to Sophia, how often Sophia had contact with the mother's friend(s), whether Sophia was afraid of the friend, and if the mother's friend(s) had a criminal history or previous DCFS involvement.

5. CWW [redacted] **developed a *verbal*** voluntary safety plan with the mother to allow visitation between maternal relatives and Sophia. The verbal safety plan was inadequate and ineffective to address concerns over Sophia's safety. The safety plan did not properly address concerns over physical abuse or corporal punishment by the mother or the mother's friend(s). The **mother told** [redacted] before the investigation closed that she would not voluntarily follow the safety plan.

6. CWW [redacted] **kept the January 22, 2021 referral open for longer than allowed by the State of California Division 31 standards.** [redacted] **documented that there were no safety threats or substantiated allegations.** Therefore, the referral should have been closed within 30 days of the initial contact with the family.

7. The Intake Supervisor evaluated out a referral that met criteria for an in-person investigation without obtaining the Program Manager's approval to downgrade the referral. The supervisor did not document a rationale on the Intake face sheet/blue sheet for changing the response decision.

8. DCFS provided insufficient protective interventions to the family given the number of referrals that arose during the open investigation, the child's disclosures, and the concerns reported by collaterals.

9. [redacted] **visited the family's temporary residence (a hotel room). However,** [redacted] **did not assess the child's last known residence where the mother lived with friend(s), including possibly Mr. Jackson.** There was no home visit to assess the safety and condition of the mother's residence once she moved to a friend's home in

February 2021. Instead, CWW [redacted] met the family at a park due to the mother saying that her friends did not want Child Protective Services involvement.

The standard of care in child welfare is to observe the overall condition of the family's home, assess for environmental safety including drug paraphernalia, observe the child's sleeping area, assess all household members, and check for basic needs including checking the refrigerator for food. Lastly, in cases where a child has a physical injury a home visit can provide valuable information in determining the mechanism of an injury. For instance, Sophia reportedly had an injury that she sustained from riding her bike. During a home visit, the investigator would have an opportunity to observe the home for the presence of a bike then inquire further about the fall.

10. There was inadequate communication between the supervisors and the investigator. The four subsequent referrals received by DCFS in February 2021 were emailed to CWW [redacted] to incorporate into the January 22, 2021 investigation. However, CWW [redacted] stated at her deposition that she never received information on at least one of the February 11, 2021 referrals involving allegations of physical abuse by Dave. Case evidence shows that the subsequent referrals were emailed to [redacted]. The hotline screener nor the Intake supervisor confirmed receipt of the new referrals.

11. There was a lack of a comprehensive global assessment for all forms of child abuse and neglect in Sophia's interviews.[5] There is no clear documentation that Sophia was asked about sexual abuse, exposure to sexual acts, substance use, or the mother's mental health. [redacted] stated in deposition that she did ask Sophia about sexual abuse; however, this information was not reflected in CWS/CMS or the investigative narrative.

12. CWW [redacted] did not ask the mother for her new address to update CWS/CMS records for future investigations or child welfare checks. Sophia was not attending school. Without a current home address or school attendance, there was limited ability for authorities to check on Sophia's well-being. Furthermore, if DCFS had obtained a home address, there would be the option of conducting unannounced home visits and request a record search to inquire if there were any criminal activity or police calls to the home.

13. There was no interview with Dave, aka Dhante Jackson, who Sophia reported to be a household member, alleged secondary caregiver of Sophia, and an alleged perpetrator of physical abuse. There were only two phone attempts to contact Mr. Jackson during the two-month investigation.

14. Sophia was not visible to the community and a vulnerable child per SDM criteria. SDM did not reflect that [redacted] identified Sophia as an especially vulnerable child due to speech difficulties, a potential developmental delay, and as a child not visible to the community due to not attending school.

15. The mother's use of corporal punishment was not sufficiently addressed during the investigation. Sophia said she was scared of the mother, that the mother hit her, choked her, covered her mouth so that others could not hear her cry, and that the mother tried to hurt her. The mother confirmed that she did cover Sophia's mouth and grabbed Sophia by the neck. Sophia also stated that the mother's friend(s) were hitting her. Despite the aforementioned, there is no case evidence that the mother was educated on the dangers of excessive discipline including how choking or grabbing a child by the neck and covering a child's mouth can

[5] CDSS MPP 31-125 The social worker initially investigating a referral shall determine the potential for or the existence of any conditions(s) which places the child, or any other child in the family or household, at risk and in need of services and which would cause the child to be a person described by Welfare and Institutions Code Sections 300(a) through (j).

lead to serious physical injury, suffocation, or death. Educating the parent on the dangers of excessive discipline is in itself a protective intervention and can inform safety planning.

16. CWW [redacted] did not update CWS/CMS with "Dave" Dhante Jackson personal information, although being provided Mr. Jackson's address, date of birth, and phone number. CWS/CMS updates are crucial to locate an alleged perpetrator on current and future investigations and conduct a background check including a child welfare history check. Moreover, information in CWS/CMS ensures that cross-reports to law enforcement agencies are sent to the correct police jurisdiction and with accurate contact information.

17. The cross report sent to Hayward Police Department contained an incorrect address for the family. The form had the family's previous address at the grandmother's home in Hayward instead of the family's new address. It is likely that the family's former address was pre-populated from the CWS/CMS database because the family's new address was not updated in State database.

18. There was no documentation in CWS/CMS or the investigation narrative to address the visual inspection of Sophia for indicators of physical abuse. The aunt and [redacted] testified that they did visually check Sophia for injuries. In deposition, [redacted] acknowledged that she did not document the body check or observations of Sophia. It is critical to document observations, visual inspections (body checks), especially in cases where there are allegations of physical abuse and there is a child disclosure.

19. There was no documentation that Sophia was asked about the allegations of substance use. [redacted] did not ask Sophia if she saw substance use in the home, either by the mother or other adults. There was no voluntary drug testing for the mother to confirm or refute the allegations that she was using cocaine. Drug testing or substance use treatment are common elements of a voluntary or Court-ordered case plan and.

20. DCFS did not adequately address the mother's mental health during the investigation. Several of the suspected child abuse reports included allegations that the mother had untreated schizophrenia and/or bipolar disorder that interfered with her ability to safely parent Sophia. The reports alleged that the mother had not been medication compliant for years, information that the mother confirmed. Collateral contact with the mother's therapist was essential in the investigation due to the mother's statements that DCFS and the mother's sister were trying to kill her which [redacted] described as "delusional thinking."

21. Investigations kept open over 30 days requires a consultation with a supervisor. There was no documentation that there was supervisory approval to keep the investigation open over 30 days.

22. Sophia was not interviewed alone at the February 11, 2021 park visit. The case notes show that the mother's case manager and the aunt were present during Sophia's interviews. [redacted] notes reflects that she had to redirect the aunt when [redacted] believed the aunt was asking Sophia leading questions. [redacted] later testified that the presence of others may have led to Sophia feeling pressured to disclose physical abuse. As a result, [redacted] doubted the truthfulness or accuracy of Sophia's statements on the second interview; despite having previously noted that Sophia appeared honest and credible. [redacted] could have ensured that there were no leading questions or outside influence if Sophia was interviewed in private and alone.

23. There was a lack of a timely investigation closure by the investigator and the supervisor. The January 22, 2021 investigation remained open for 60 days by CWW [redacted] Then the investigation was left open for another 30 days by the DCFS Supervisor. The investigation was officially closed on April 21, 2021.

24. DCFS failed to respond to a referral that met the criteria for an-person response as required by State mandates.[6] The February 11, 2021 referral was downgraded from an in-person response to a Evaluated Out and incorporate with the open investigation.

25. SDM was not submitted for supervisor review and approval on time. SDM was completed on January 27, 2021 and sent for supervisory review on March 22, 2021. The supervisor approved the safety and risk assessments on April 21, 2021.

26. Maternal relatives informed DCFS that they were interested in pursuing legal custody of Sophia through legal guardianship. [redacted] did not follow up or refer the relatives applied for legal guardianship of Sophia.

27. DCFS did not hold a Child Family Team Meeting (CFT) to bring the family together to discuss the numerous concerns and referrals. A CFT would have allowed discussion of placement options, family strengths, and safety planning. There would also been further assessments if there was sufficient to preserve the family unit without removing Sophia from the mother's physical custody and if there was sufficient evidence to substantiate the allegations. Although the mother declined to voluntarily participate in a meeting, [redacted] could have still met with DCFS staff, a supervisor, collaterals, and relatives to safety plan for Sophia.

28. There appeared to be an overreliance on community members to provide information or follow-up on elements of the DCFS investigation. Community members included the mother's case manager and the maternal aunt who were instrumental in collecting and reporting information about Sophia's location, safety, and well-being. For example, the case manager conducted frequent check ins with Sophia and the mother. The case manager was the last person to see Sophia in person before the investigation closed. The aunt was instructed to call police for a welfare check when the aunt provided Sophia's new location during an open investigation instead of the CWW conducting an unannounced home visit or calling law enforcement for a welfare check for Sophia.

29. A new SDM safety and risk assessment is required when there are changes in the household. A new SDM was not completed when the family moved from a hotel to live with the mother's friend(s) and allegedly the mother's boyfriend, Dhante "Dave" Jackson.

JUNE 2021 REFERRAL

On June 16, 2021 at 8:44 PM, the County of Alameda DCFS received a *seventh* referral. The referral alleged physical abuse to Sophia. The caller observed Sophia to currently have "marks on her arms from the wrist to the elbow" and three small quarter-sized circular marks. The caller noted that Sophia appeared nervous and afraid to talk. Sophia told the reporting party that no one hurt her and that she hurt herself on the monkey bars. Additionally, the caller claimed that the mother was prostituting herself and using cocaine. Sophia was reportedly at the grandmother's home for a few days which would have allowed for an in-person investigation. The caller noted that the relatives were planning to file for legal guardianship.

This referral was evaluated out as a duplicate referral. Therefore, the referral was not assigned to an emergency response worker for an in-person investigation. The allegations of drug use and prostitution had previously been reported to DCFS. The hotline screener noted that there was no child disclosure of physical abuse. However, SDM allows for other behavioral indicators of abuse to be considered in the response assessment. A child appearing fearful is one criterion that can elicit an in-person investigation, regardless if there is a child disclosure of abuse. Other criteria described by the caller were observed injuries to Sophia.

[6] CDSS MPP 31-101.1 The County shall respond to all request for services which allege that a child is in danger by abuse, neglect or exploitation.

The three circular marks described could have been a result of being hit by an object or finger marks if the child's arms were grabbed. The hotline screener focused on the fact that the child did not disclose physical abuse instead of the other indicators of abuse such as behavior, fear, and the child being afraid to speak.

Notably, the screener did not thoroughly complete the SDM Hotline response assessment. The SDM physical abuse decision tree indicated that an Immediate response was required due to prior allegations of physical abuse and the fact the child was vulnerable or fearful. The remaining SDM form including screening criteria and the screening decision was left blank. The CPS Intake form showed the decision was made to Evaluate Out the referral. DCFS's decision did not match SDM's recommendation of an Immediate response within 24 hours of the time the referral was received by the hotline.

THIRD DCFS INVESTIGATION

DCFS conducted their third and final investigation involving Sophia Mason in October 2021.

On September 30, 2021 at 8:09 PM, the DCFS hotline received a new suspected child abuse referral. A mandated reporter in the city of San Leandro called in a suspected physical abuse involving Sophia who showed up to the medical facility with the mother after a motor vehicle accident. The hotline screener assigned the referral as an Immediate response due to allegations of suspected physical abuse.

The *Provisional Harm Statement*:

> It was reported that minor has bruising to her right hip and back, to include old scars on body that appear to be old cigarette burns and are being reported as "suspicious in nature." It was reported that the mother and minor were in a car accident today in a Lyft. It is reported that attending physician [redacted] completed a physical exam and observed bruising to minor's right hip and back (Details regarding bruising unknown per RP). When mother was asked about the bruising, mother stated that minor had fallen on monkey bars (Details unknown). Minor was also observed with some markings to her body that appeared to be old cigarette burns/marks. When mother was questioned about these marks, mother stated that they were from ice packs that been left too long.

One hour after the initial call, the mandated reporter called the hotline to report additional information:

> Update, reporting party called the hotline back at 9:00 PM from medical facility to report that the mother and minor child had left AMA (Against Medical Advice) at 8:17 PM before the medical facility could conduct a "skeletal survey" for suspicious injurious.

The Intake Supervisor, [redacted] initially assigned the investigation to CWW [redacted]. On the morning of October 1, 2021, [redacted] attempted to see Sophia at school and her grandmother's house but was unsuccessful. [redacted] obtained the family's current address in San Leandro from school records. [redacted] then called the mother, who initially refused to meet with the CWW and hung the phone up. After multiple tries, [redacted] was able to set up a home visit for 3:30 PM the same day. The mother called [redacted] when the CWW did not show to the appointment. [redacted] did not attend the scheduled appointment due to a scheduling conflict that required [redacted] to attend a meeting with a different family. [redacted] told the mother that another DCFS investigator would attend the appointment. The case records do not reflect that any DCFS worker attended the October 1, 2021 appointment at 3:30 PM with the Johnson Mason family.

DCFS did not see Sophia within the 24-hour State mandate, although attempts were made to see Sophia earlier that day. Since [redacted] was unavailable to meet with the family, an Intake Supervisor should

have sent a different Emergency Response worker for the scheduled meeting. It is critical for children suspected to be in an abusive situation with reported injuries to be seen within the designated period to prevent any possible additional abuse or injury. In Sophia's case, the family was transient and difficult to locate. Sophia was not attending school. As such, it was even more crucial to meet with the family at the scheduled time and location agreed upon by the family. Honoring the family's appointment aids with engagement, building rapport, and ensures there is not a missed opportunity to check on an at-risk child.

Internal DCFS emails reflect that the referral was scheduled for assignment to a swing shift Emergency Response worker. For unknown reasons, the referral was not assigned to a new investigator until the next day. On Saturday, October 2, 2021, the referral was re-assigned to CWW [redacted] met with the mother and Sophia the same day he was assigned the referral. **This would be the last time that someone from Alameda County DCFS physically met with Sophia in-person.**

Multiple photographs taken as part of the medical evaluation revealing substantial bruising to Sophia's arms, thighs, and back as well as what appeared to be old cigarette burns and scarring on Sophia's arms. The photographs show what appears as red linear marks across Sophia's back and substantial bruises in varying colors. Sophia had multiple large purple and red bruises across her body, most substantially across her outer hip/thighs and multiple circular purple bruising on her inner thighs/groin area.

The medical chart reflected that the doctor had ordered a child abuse workup including a skeletal survey. The child abuse workup tests and surveys were not completed due to the mother leaving the hospital with Sophia against medical advice (AMA) which was immediately reported to DCFS. An excerpt from Sophia's medical chart for the medical visit on September 30, 2021 contained essential information and physical evidence (photographs of Sophia's injuries) that was crucial for a DCFS suspected child abuse investigation:

> DIFFERENTIAL DIAGNOSIS AND PLAN
>
> Medical Decision-Making
>
> This is a 7 Y female who presents to the emergency room with a chief complaint of NECK PAIN (Lt side neck pain after minor mva.no damage to both cars. clinic called for poss. abuse).
>
> Pt with possible minor neck muscle strain from minor MVC Immediately PTA. **Injury pattern of RLE bruising not consistent with this Mechanism**. Concerns arise from called in report of suspected child abuse. Scaring on RUE *(right upper extremity)* explain by mother as resulting from the patient "leaving an ice pack on her skin for too long". Mother further asked about the state of the skin following the exposure to the ice pack. Mother states that the skin was red but there was not skin breakdown. It is less likely that scarring would result from that mechanism of injury.
>
> Will consult SW and Peds HBS. Suspected Child abuse order set used as guideline for labs and imaging.

Structured Decision-Making

CWW [redacted] completed the Structured Decision-Making (SDM) safety and risk assessments for the September 30, 2021 referral on time. The safety assessment indicated that Sophia was *Safe* and there were no safety threats identified by [redacted]. The safety assessment is a series of yes or no questions to identify potential safety threats. The SDM risk assessment results showed that *the family* had a Moderate Risk for

future caretaker maltreatment. It is important to note that SDM results are only as accurate as the information entered by the user. Since [redacted] did not know of bruising on thighs (the information was not in the screener report), did not review Sophia's medical records or photos of the child's injuries; [redacted] did not accurately identify safety threats or the presence of serious physical injuries.

The CWW did not identify any SDM safety assessment for the September 30, 2021. Since no safety threats was identified, there was no protective intervention required for the CWW to pursue. However, this reviewer opines that multiple SDM safety threats were present and would have been identified if a thorough investigation had been completed including interviews with collaterals, consultations with medical doctors, and review of the medical chart. The safety threats identified by this review are outlined below.

- ***Safety threat #1***. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation as indicated by serious injury or abuse to the child other than accidental, or caregiver fears he/she will maltreat the child, threat to cause harm or retaliate against the child, domestic violence likely to injure child, excessive discipline or physical force.

- ***Safety threat #3***. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and or medical or mental health care.

- ***Safety threat #6.*** Caregiver is unable or unwilling to protect the child from serious harm or threatened harmed by others this may include physical abuse, sexual abuse, or neglect.

- ***Safety threat #7.*** Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

Complicating Factors

The following risk factors and complicating factors were identified from the October 2, 2021 investigation:

- Kaiser report that injuries were suspicious of child abuse.
- Mom left AMA prior to the skeletal survey.
- Mom refused to initially meet with the social worker or produce the child to DCFS.
- Prior referrals for Physical Abuse by mother and Dhante.
- Mom's mental health. Family states that the mother has not been compliant with her medication.
- Neighbor said mom was crazy to CWW [redacted].
- Mom's alleged prostitution; sexual activity exposure to Sophia.

Results of Investigation

[redacted] determined the allegations of suspected physical abuse to Sophia was Unfounded. [redacted] concluded there was no abuse without interviewing the reporting party, collaterals, or medical providers. The mother's explanation for reported old cigarette burns on Sophia was not addressed. [redacted] noted there were no marks or bruises indicative of abuse despite contradicting medical evidence. [redacted] did not request or review crucial medical documentation from the hospital. If he had contacted the hospital, spoken

to the reporting party, or reviewed Sophia's medical records, he would have obtained information along with photographs that medical providers took of Sophia's suspicious injuries.

Other limitations with the investigation included missed identification of numerous injuries on Sophia's body including her arms, legs, and back. The injuries were located where they may have not been visible under clothing. The male investigator should have been able to at least visually check Sophia's arms to see the healed scars of what appeared to be old cigarette burns in a circular pattern located near the wrists and an older large dark scar on the inner right arm. Sophia should have been examined by a medical provider and/or scheduled a forensic medical exam. The investigation occurred two days after the medical provider photographed the injuries. Therefore, it is doubtful that the injuries would have healed by the time the investigator met with Sophia.

The investigation was closed without Sophia ever having a skeletal survey or imaging, despite medical providers recommending the imaging to evaluate for fractures and historical injuries. There was no consultation with medical providers, a supervisor, or a child abuse pediatrician specialist to assess if Sophia's multiple suspicious injuries were consistent with a vehicle accident or ice packs left on the skin as the mother claimed. In addition, DCFS did not seek a medical exam warrant to seek a physical exam of Sophia.

Other limitations with the investigation included that [redacted] did not look up the mother's prior child welfare history before meeting with the family. Step 1 of the Alameda County Emergency Response protocol is to look up the family's prior DCFS history. If [redacted] had thoroughly reviewed the family's history, he would have been aware of the history of multiple physical abuse allegations and Sophia's prior disclosures of corporal punishment by the mother and the friend.

A cross report was made to San Leandro Police Department to inform them of the suspected child abuse report. However, the family's old address in Hayward was erroneously listed on the form. It is likely that the family's previous address at the grandmother's home was pre-populated from the CWS/CMS database. The family's new location in San Leandro should have been updated before the closing the investigation and generating the cross-report. It is unlikely that the San Leandro Police Department could investigate a report for a family that lived outside of their jurisdiction.

Lastly, [redacted] closed the investigation within one day of assignment. Although there is no minimal timeframe for a DCFS investigation, an investigation must be timely, thorough, accurate, and follow the standards set by Emergency Response policies. The investigation narrative was submitted to the supervisor along with the completed SDM. Supervisor [redacted] approved the investigation for closure on October 6, 2021.

Deficiencies Identified in the Investigation

1. There was no attempt to contact medical providers or the reporting party to gather more information about the observed injuries on Sophia that were suspicious of physical abuse and sexual abuse.

2. The SDM safety and risk assessment were inaccurate and the corresponding safety threats were not correctly identified.

3. The family's previous correct address in Hayward was sent to San Leandro Police on the suspected child abuse cross-report. The correct child's location at the sober living home in San Leandro was not provided to law enforcement for them to conduct an independent criminal investigation of physical abuse to Sophia. It is unlikely that San Leandro Police could investigate suspected child abuse outside their city limits/jurisdiction and without having the correct address to locate the child victim.

4. The sober living home manager was not interviewed in regards the mother's sobriety, results of any drug testing, and/or current or past use of substances. The fact that the mother and Sophia were living in a sober living home does not in itself provide sufficient information about the mother's substance use history or sobriety. However, there was a history of allegations that the mother used cocaine in 2021. Of not, in March 2022 the mother told Merced Police that she had been sober for only 4 months.

5. The investigation was initially assigned as an Immediate response to CWW [redacted] on October 1, 2021. When [redacted] was unable to meet with the family that same day, the referral was set for reassignment to a worker in the swing shift. For unknown reasons, there was an overnight delay to re-assign the referral to a new investigator.

6. The referral of September 30, 2021 alleged that Sophia had old cigarette burns on her body. [redacted] did not document seeing any healed or new injuries, bruising, or cigarette burns marks or scars. No photographs were taken of any observed injuries. The investigative narrative did not indicate that the mother was interviewed for an explanation of the historical cigarette burns nor that the marks were observed. Sophia was not asked about the cigarette burns. Therefore, it is unknown if, who, why, and when Sophia suffered physical abuse including cigarette burns. Historical cigarette marks was a tremendous red flag that Sophia had suffered physical child abuse by an unknown person since cigarette burns are more likely to be inflicted by intentional means versus as a result of a nonaccidental injury.

7. The investigation did not accurately document or photograph Sophia's marks or injuries.

8. There was a failure to review medical charts, photographic evidence as required by County of Alameda Emergency Response Policy. CWW [redacted] reported that he could not review Sophia's medical records due to HIPPA. It is the standard of practice to request and review medical records as part of an investigation.

9. CWW [redacted] did not thoroughly review Samantha Johnson's case history, criminal record, and prior investigations which contained crucial information to give context to the overall investigation.

10. No collateral, medical resources, or multidisciplinary sources were not contacted during the investigation.

11. The presence of domestic violence in the household was not explored in the interview with Sophia.

12. There was no documentation of a supervisory consultation to support decision-making including discussing having the mother take Sophia for a skeletal survey after leaving against medical advice.

13. There was a lack of review of prior DCFS allegations and prior investigations. The investigative narrative indicated that the mother told the investigator that she did not use corporal punishment with Sophia. Yet, the previous investigation eight months prior contained Sophia's statements that the mother hits Sophia.

DCFS Protective Interventions

State and Federal mandate require that DCFS consider and implement the least restrictive services available to keep a child safe. DCFS should have considered all of the available protective interventions available to ensure Sophia's safety, well-being, and permanency. The various courses of action available to DCFS as protective interventions are briefly described below.

- *No Intervention*- When DCFS determines that no child abuse or neglect occurred and no intervention was necessary to protect the child from future maltreatment. No intervention is an option when DCFS finds an unfounded or inconclusive allegation of abuse and there are no concerns for the child.

- *Voluntary Placement-* A case management and placement option when a parent voluntarily agrees to allow the placement of a child without Court intervention. This option is used in cases where a parent may be incarcerated or otherwise unavailable or unwilling to care for a child.
- *Informal Family Maintenance Services* - Case management services and support provided to caregiver(s) and their child *without* court involvement or Juvenile Court oversight.
- *Formal Family Maintenance Services-* Case management services offered under the supervision of the juvenile dependency court with a Court-ordered case plan. The case plan includes services and monthly home visits to the parents and child in order to preserve the family unit.
- *Family Reunification Services-* Reunification services when a child is removed from the parent's custody and there is no safety plan that would mitigate the identified risk of harm to allow the child to remain at home. The child is placed in a foster care or relative placement.
- *Permanency Placement-* Adoption, Long-term foster care, or Legal Guardianship are pursued when family reunification efforts fail or there is no parent available to reunify with the child within the federal and state timelines (i.e. incarceration, incapacity, unwillingness to care for the child), or in cases when the parent waives family reunification, or there are legal exceptions to reunification services.

CWW [redacted] offered the mother housing resources and a CFT which the mother declined. The mother declined to adhere to a safety plan to allow relatives to see Sophia. DCFS offered the resource *Another Road to Safety* which the mother declined. Another Road to Safety is a voluntary program for cooperative families who are willing to receive services without Court intervention. The parent must have non-acute mental health issues that does not affect child safety.

Thoughtful consideration must be made towards more protective interventions when DCFS encounters a parent that is not willing to consider voluntary services or commit to a safety plan and there are concerns for the child's safety. There needs to be continuous assessments of the family's needs, safety concerns, and risks of abuse and neglect. Assessments need to begin before the first contact by thoroughly reviewing the family's child welfare history, past DCFS interventions, and services provided or offered to the family in past interactions.

There was a lack of safety planning that addressed corporal punishment. The mother may have agreed to a voluntary placement in lieu of having Sophia taken into protective custody. A safety plan could have allowed Sophia to stay in a safe environment with relatives temporarily until a dependency Court order was sought or until the relatives could petition for temporary or permanent legal guardianship.

In the alternative, if the relatives could not keep Sophia safe from the mother, such as if the mother would return to the home to remove Sophia, then a confidential out-of-home placement with a non-relative may have been the most appropriate placement. A confidential foster care placement would have ensured Sophia's safety under the Juvenile Court and DCFS supervision. It is important to note that an out-of-home foster care placement would only be an option if the allegations of abuse or neglect were substantiated. None of the DCFS investigations led to a substantiated allegation of abuse or neglect. It is likely that family reunification would have been the only appropriate protective intervention had the last investigator, CWW [redacted] observed Sophia's injuries, reviewed medical evidence, and scheduled a CALICO forensic exam.

Process for Child Removals

The removal of a child from a parent's custody should only be considered if DCFS determines there is no

other means to assure the child's safety. There must be a substantiated allegation of child abuse or neglect to demonstrate that a child falls under Welfare and Instructions Code (WIC) 300 for DCFS to recommend to the Juvenile Court order mandatory services for a family, supervise a family, or remove a child from the home. There are multiple public agencies that have authority to intervene or remove a child from an unsafe caretaker including: Law Enforcement, Juvenile Court, Probate Court, and Child Welfare Services/DCFS.

Placement Considerations

Federal mandates specify a required order of placement preference for child welfare agencies to follow in placement considerations. First and foremost, family preservation is paramount and must be considered if the child can safely remain with the offending parent or non-offending parent. The next priority is placement with a relative or a tribal member. Placement with a non-related family members such as a godparent, family friend, or other fictive kin are the next preference. Foster care with a family unknown to the child is the last preference for an out-of-home placement. Foster care is typically a confidential placement, adding an element of safety for the child in specific cases such as when a parent may attempt to abscond with a child.

Equity Lens

The mother had an identified developmental disability, mental health condition, and was a Regional Center client. Sophia was a child with a potential learning disability of a speech-language delay. Sophia was a child of African American ethnicity. African American children are disproportionality overrepresented in the child welfare system. It is unknown if the County of Alameda's efforts to reduce disproportionality of African American children in foster care and preserve families was a factor in the decisions made to preserve Sophia at home with the mother. The County of Alameda's 2024- 2029 System Improvement Plan (SIP) reports a commitment to reducing disproportionality for African American children (p. 9):

> "… a visible commitment to keep racial equity, inclusion, and justice at the center of case decisions. These efforts and more have produced positive changes in safety, permanency, and well-being outcomes for all children and families as well as reducing disparities for African American children in foster care."

Summary of Findings

This section of the report addresses the findings of the case review. The findings are divided into two main sections: (1) Where the DCFS responses met child welfare practice expectations (2) Where there were breakdowns in the Child Welfare responses.

Strengths: *Where child welfare practice met practice expectations.*

DCFS maintained a 24-hour hotline, received, and documented calls of concern over Sophia's well-being from community members.[7] The hotline screeners documented the various calls in CWS/CMS, reviewed prior DCFS history, and forwarded the referrals meeting criteria for an in-person to the Emergency Response Unit Intake Supervisor for assignment. DCFS assigned a Child Welfare Worker (CWW) from the Emergency Response Unit (in Alameda County to investigate the suspected child abuse referrals (March 2014; January 2021; multiple referrals in February 2021; September 2021).

[7] CDSS MPP 31-105 MERGENCY RESPONSE PROTOCOL requiring documentation of calls from the community including allegations, injury description, child/family characteristics, presence of parent substitute, information regarding a records review of prior child welfare services history involving household members and alleged perpetrator(s).

DCFS located the family to conduct the referral investigations. [redacted] saw Sophia in-person on three separate occasions in 2021, the year of the bulk of the DCFS referrals. DCFS's initial contact with Sophia was timely for the January 22, 2021 referral meeting the State's mandates.

The child abuse hotline and DCFS investigators consistently used Structured Decision-Making to screen the suspected child abuse or neglect referrals and conduct risk assessment. DCFS offered the mother protective interventions including a Child Family Team Meeting, housing assistance, and a referral to Another Road to Safety. The mother refused all DCFS services.

Collaterals were contacted during the DCFS investigations. CWW [redacted] contacted multiple collaterals including maternal relatives, the mother's Regional Center case worker, and Sophia's teacher. CWW [redacted] communicated with Sophia's pediatrician. CWW [redacted] attempted to interview Sophia in-person at school and at the maternal grandmother's home. CWW [redacted] interviewed the sober living home manager. CWW [redacted] contacted law enforcement for assistance during a visit with the mother and Sophia in February 2021. DCFS made cross-reports to law enforcement for suspected child physical abuse referrals.

Breakdowns in the Child Welfare Response: *Where child welfare practice standards were not met.*

DCFS did not file a petition in juvenile court to have Sophia declared a child described by Welfare and Institutions Code section 300. If a petition had been filed, a court hearing would have been held at the Juvenile Court where a judicial officer would decide if there was enough evidence to show that Sophia was an abused or neglected child or at risk of abuse. Sophia may have come under formal court and DCFS supervision, with a structured placement either with a safe relative, in foster care, or, if appropriate. Alternatively, Sophia may have been left in the care of her mother under a court-supervised family maintenance plan with DCFS monitoring Sophia's safety.

A DCFS Intake Supervisor assigned the February 11, 2021 referrals to be addressed at the same time as January 2021 investigation. The information of the subsequent referral was emailed [redacted]; however, [redacted] stated she did not receive the referral. Therefore, the new allegations of suspected abuse and neglect were not investigated or addressed on at least one referral.

In February 2021, a new call of suspected abuse and neglect to Sophia was screened-in for an in-person investigation by DCFS. After completing a SDM hotline tool, the hotline screener determined the priority of the call as an in-person Immediate response. However, the Intake Supervisor downgraded the response level from an in-person response to a *duplicate* referral. Duplicate referrals do not activate a new child interview, parent interview, or DCFS investigation. Although some parts of the new referral contained duplicate allegations as previous referrals; there were also new facts and information to warrant a new investigation. For one, the new referral contained allegations of suspected physical abuse to Sophia by "Dave."

DCFS policy requires that a DCFS program manager approve any downgrades of a response level for a new suspected child abuse referral. The Intake Supervisor did not communicate with the DCFS program manager or seek approval to downgrade the new referral involving Sophia. The Intake Supervisor did not document the consultation with a manager in CWS/CMS or note a rationale for changing the screening on the intake form.

In June 2021, DCFS received a suspected physical abuse referral that met criteria for an Immediate investigation due to current suspicious injuries and behavioral indicators of fear. However, the hotline

screener changed the screening decision to Evaluate Out/duplicate. The hotline screener did not thoroughly complete the SDM hotline tool and left most of the form blank. As a result, DCFS failed to investigate the June 2021 referral that alleged physical abuse to Sophia by the mother's live-in boyfriend, Dhante "Dave" Jackson. Although the caller noted observing a current injury on Sophia that same day; the hotline screener noted the call as a duplicate to a previous allegation and historical. A new and current injury occurring four months after the last DCFS investigation cannot be a duplicate allegation. The hotline screener and the Intake Supervisor should have reviewed SDM for the physical abuse criteria and assigned the referral for an in-person investigation given new injuries observed on the child.

Sophia made statements to investigators that the mother had choked her, that she was living with the mother and the mother's friend "Dave." During the park interview, [redacted] noted that Sophia quietly said, "*Someone is hitting me.*" Sophia initially denied that the someone hitting her was the mother. CWW [redacted] then asked Sophia if the mother's friends were hitting her, to which Sophia responded "yes." There were no other questions asked to inquire further about the mother's friend or friends hitting her. Later in the interview, Sophia stated the mother used corporal punishment, "she hit me a little bit. She spanked me on the side of the leg." When [redacted] asked her why the mother hit her, Sophia stated *"she wanted to hurt me."*

Sophia stated that some of her injuries resulted from ordinary childhood play such as playing on the monkey bars or falling off a bike. It is unknown if Sophia had a bike as there was no notation of a bike observed at the hotel and the family was transient. A home visit was not conducted at the mother's residence when she moved out of the hotel with "friends."

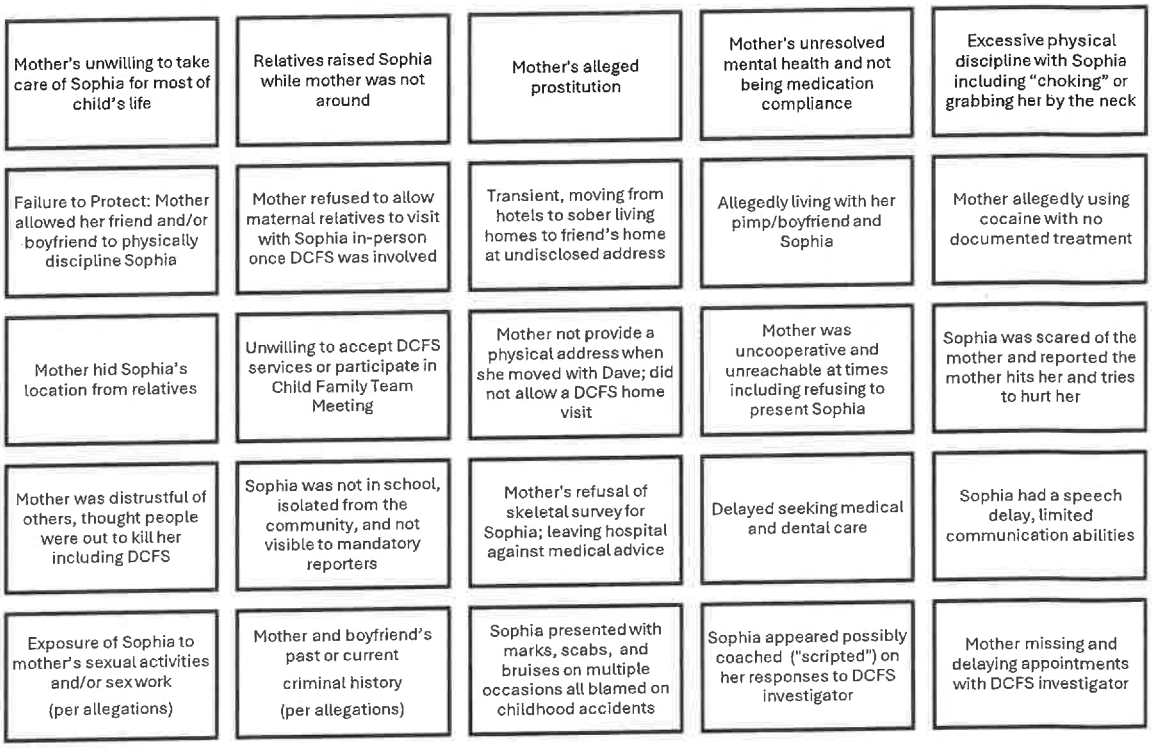
CWW [redacted] noted that Sophia's responses seemed "scripted" at times in responses to questions. [redacted] further stated in deposition testimony that she did not believe Sophia's disclosures of physical abuse, did not believe the mother's discipline rose to the level of abuse, and she did not observe any bruising on Sophia. [redacted] testified that it seemed that Sophia was pressured into making the allegations of physical abuse. [redacted] did not consider the alternate scenario that Sophia was telling the truth and perhaps was minimizing the level of physical abuse or withholding information out of fear or wanting to protect others.

Sophia did not make any disclosures of abuse during the last DCFS investigation in October 2021. The mother reported she did not physically discipline Sophia. The investigator CWW [redacted] did not observe any marks or bruises indicative of abuse on Sophia. [redacted] closed his investigation after having no concerns for child abuse and without reviewing medical evidence including photographs showing multiple suspicious injuries on Sophia. Ultimately, DCFS classified all allegations of suspected physical abuse or neglect as either unfounded or inconclusive.

Sophia's alleged biological father, [redacted], whereabouts were unknown. There was no attempt to conduct an absent parent search or search for parental relatives that may have been viable options to offer additional support for Sophia and the mother. Absent parent search units locate missing parents through a number of databases including but not limited incarceration records, mailing records, CWS/CMS name searches, and social media. An absent or noncustodial parent is not always included in the initial stage of an ER investigation and depends on the case specific circumstances. However, the child's other parent may have valuable information to contribute to an investigation such as parenting concerns, prenatal history, medical history, and other safe relatives to support the child. If a child removal becomes necessary, a non-offending parent and relatives should be assessed as a placement options as mandated by law.

Missed Red Flags

The following diagram contains red flags that were known to the Alameda County DCFS at the time of the 2021 investigations. DCFS did not address the red flags sufficiently or else did not address the risk factors at all during their contact with the family.



Conclusion

Between January and October 2021, DCFS received multiple referrals alleging abuse or neglect of Sophia. Although the agency responded to several of those referrals, the case review identified significant failures in how critical information was assessed, documented, and acted upon.

During the final investigation in October 2021, Sophia presented with injuries across multiple areas of her body, including bruising, healed burn-like marks, and other red marks potentially indicative of abuse. The treating physician reported concern that the injury pattern was suspicious and recommended a skeletal survey to evaluate for physical abuse; however, Sophia left the medical facility with her mother before that exam was completed.

The assigned investigator did not adequately document or recognize Sophia's injuries or review medical records containing critical evidence and photographs. DCFS did not ensure that a medical examination with skeletal survey was completed for Sophia before the investigation was closed. Instead, the injuries were attributed to a motor vehicle accident or childhood accidental injuries. In the January 2021 to March 2021 investigation, the DCFS investigator similarly discounted signs and disclosures of physical abuse. The investigator later testified that she did not believe Sophia's disclosure that she was being hit nor conclude that Sophia was a physical abuse victim.

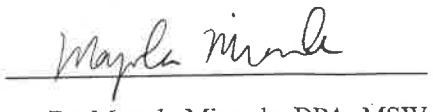
The record also reflects repeated failures to integrate and respond to new allegations and emerging safety concerns. Protective interventions were limited to a verbal safety plan and community referrals. These interventions were ineffective and did not address the various allegations or risk. In addition, supervisory oversight within the Emergency Response Unit was insufficient to ensure the investigations were timely, thorough, accurate, and aligned to the family's identified needs.

Documentation deficiencies further weakened the DCFS response. The family's updated residence was not entered into CWS/CMS which resulted in inaccurate cross-reports to law enforcement with outdated addresses for the family. On the October 2021, the cross-reports the address was mistakenly listed as the city of Hayward and the report was sent to San Leandro police. This limited the ability for police to conduct an independent criminal investigation of alleged physical abuse or check on Sophia's well-being.

Overall, the case review of Sophia C. Mason shows systemic failures in recognizing safety threats, accurately assessing risk, and implementing adequate protective interventions. It supports the conclusion that Sophia experienced repeated physical abuse by the mother and her boyfriend, neglect and failure to protect by her mother, sexual abuse by the mother's boyfriend at an unknown date(s), and ultimately fatal child maltreatment by her caretakers.

Sophia's case highlights broader vulnerabilities in child welfare Emergency Response practice and underscores the need for corrective action beyond this matter. Improvements are warranted in policy development, policy enforcement, supervisory oversight, staff training, documentation standards, and quality assurance to strengthen future investigations and better protect vulnerable children.

Report Prepared by:



Dr. Mayola Miranda, DPA, MSW

Licensed Clinical Social Worker

Dated:

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