ORIGINAL

SULLIVAN COUNTY
SPECIAL GRAND JURY
TERM 5A

April 26th, 2023 - January 16th, 2024

GRAND JURY REPORT
CPL § 190.85(1)(C)

STATE OF NEW YORK }
}ss.:
SULLIVAN COUNTY CLERK'S OFFICE }

I, Russell Reeves, County Clerk in and for said County, do hereby certify that I have compared the foregoing copy of a Grand Jury Report Pursuant to CPL 190.85(1)(C) Pages 1-100 with the original now remaining on file in this office and that the same is a correct transcript therefrom and of the whole of said original.

In testimony whereof, I have hereunto set my hand and affixed the seal of said County this 4th day of January A.D., 2024

ENDORSED, FILED.
1-3-2024

RUSSELL REEVES
COUNTY CLERK

Tara Hirsch
TARA HIRSCH
Acting Deputy County Clerk

ORIGINAL

SULLIVAN COUNTY
SPECIAL GRAND JURY
TERM 5A

April 26th, 2023 - January 16th, 2024

GRAND JURY REPORT
CPL § 190.85(1)(C)

DATED: August 31, 2023

Foreperson
County Court, Special Grand Jury
Term Ending January 16th, 2024

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I. PRELIMINARY STATEMENT

The Sullivan County Grand Jury, Term 5a, was empaneled on April 26, 2023 to conduct an investigation and propose recommendations for legislative, executive or administrative action in the public interest based upon stated findings. The impetus for the investigation stemmed from the tragic loss of a sixteen (16) month old child, found unresponsive and later pronounced dead due to an apparent fentanyl overdose.

The Grand Jury heard testimony from twenty (20) witnesses, composed of both current and former Department of Social Services ("DSS") employees, members of law enforcement, and a legal professional. In addition, the grand jury considered eighty-four (84) exhibits, consisting of hundreds of pages of documents, including case files, notes, statistics, emails, manuals, photographs, and video evidence.

As a result of the investigation the following report has been adopted, pursuant to New York State Criminal Procedure Law Section 190.85(1)(C), and it is respectfully submitted to the Court.

II. FINDINGS OF FACT

All of the Findings made in this report have been made by a preponderance of the evidence.

A. Background

The Sullivan County Department of Social Services is comprised of several departments including Child and Health Services Division which is made up of Child Protective Services ("CPS"), Preventive Services, Family Assessment Response ("FAR"), and Foster Care Services; the Temporary Assistance Division which is comprised of Housing, Supplemental Nutrition Assistance Program ("SNAP"), and Medicaid; a Special Investigations Unit; a Child Support Enforcement Unit; and an Accounting department. The New York State regulatory body overseeing the local Child Protective Service Units is known as the Office of Children and Family Services ("OCFS").

1. DFS Legal

For more than twenty years, DSS was represented by a separate staff of attorneys dedicated solely to DSS and their legal requests; this group of attorneys and administrative staff were commonly referred to as DFS (formerly the Department of Family Services now known as DSS) Legal. DFS Legal had different staffing levels during different times, but generally DFS Legal contained a supervising attorney who supervised the work of three attorneys and two members of support staff. The supervising attorney was responsible for the legal practices of their staff and reported to the Commissioner of Social Services for administrative purposes. The Commissioner did not make legal determinations and those decisions were left squarely to the Supervising Attorney. The supervising attorney was also responsible for training staff, dealing with personnel issues, ordering supplies, and annual reviews of the employees within DFS Legal. The supervising

attorney wrote, reviewed, and filed petitions, attended court appearances, conducted hearings and trials, and prepared court orders.[1]

During the majority of the time DFS Legal existed, the caseworkers employed by DSS were permitted to, and did, draft their own petitions with the assistance of a manual created by DFS Legal at which point the petitions were reviewed by DFS legal for sufficiency.

DFS Legal has been characterized as working collaboratively to get the evidence needed to take the legal action requested by members of DSS, the client. If DFS Legal did not believe the caseworker had enough evidence to file a requested petition they would communicate that to their client and direct the client to return with specific evidence that was needed to proceed with the petition. Upon retrieving the information a petition was filed. Caseworkers were welcomed and expected to be present in court and at the table next to DFS Legal staff to consult with the DFS Legal attorney in order to assist that attorney in answering any questions the court may have regarding their case.

DSS staff had substantial and unfettered access to the Attorneys and Supervisor on the DFS Legal staff. The staff was available over the phone or could be reached by entering their offices; in addition, DFS Legal staff were available after hours to consult with DSS staff. The testimony before the grand jury represented that the relationship was not oppositional, DFS Legal staff responded promptly to DSS staff, there were very quick turnarounds when requesting petitions, few errors in drafting orders, petitions were filed often, removal proceedings were conducted often, and the client's wishes were largely respected as long as an argument could be made in court for the requested action. Furthermore, DFS Legal consulted DSS when making determinations about case objectives, settling cases, and whether to proceed with Fair Hearings. The evidence presented

[1] See Grand Jury Exhibit 60 and testimony of Witness 16.

before the grand jury further demonstrated that no petition filed by DFS Legal for at least twenty years of their existence and operation had been found to be frivolous by a court of competent jurisdiction.[2]

Statistics kept and provided by the New York State Unified Court System show that DFS Legal aggressively filed petitions for abuse or neglect. In 2013, DFS Legal filed 159 petitions; in 2014, 210 petitions; in 2015, 198 petitions; in 2016, 240 petitions; in 2017, 165 petitions; in 2018, 238 petitions; in 2019, 224 petitions; and, in 2020 (COVID shutdowns began March of 2020), 113 petitions (DFS Legal disbanded May of 2021). In 2019, DFS Legal removed 42 children from the home; in 2018, 35 children were removed from the home; in 2017, 98 children were removed from the home; in 2016, 86 children were removed from the home.[3] The number of reports received by Sullivan County CPS has remained relatively constant over the years, dating back to and beginning in 2018, 1,140 reports were received; in 2019, 1,123 reports; in 2020, 948 reports; in 2021, 1,061 reports; and in 2022, 1050 reports.

2. DFS Legal is Disbanded and Reinstituted Under the County Attorney's Office

On May 20, 2021, the Office of the Sullivan County, County Attorney presented a resolution to the Sullivan County Legislature proposing the abolition of the four Department of Family Services Attorney Positions (those which constituted DFS Legal) and the creation of three Assistant County Attorney positions that would be primarily responsible for handling matters involving the Department of Family Services. The proposal was adopted by the Legislature and DFS Legal was abolished.[4] Testimony before the grand jury revealed that the Office of the County Attorney eliminated caseworkers' ability to draft petitions, that all requests for petitions were

[2] See Grand Jury Testimony of Witness 16.
[3] Grand Jury Exhibit 63.
[4] Grand Jury Exhibit 96.

required to be approved by the Office of the County Attorney.[5] Witness 7 testified that there was a dramatic shift when going from DFS Legal to the Office of the County Attorney and petitions went from frequently being granted to being a very rare occurrence. As an example, Witness 10 testified that they averaged fifteen (15) abuse and neglect and derivative abuse and neglect cases per year when working with DFS Legal and under the Office of the County Attorney the average had dropped to about three (3) per year.

The credible testimony further reflected that requests to the County Attorney's Office were mired with delays in decision making about whether to file a petition and then additional delays in preparing the necessary documents.[6] Despite the relatively flat line number of hotline reports received by Sullivan County CPS, after assuming responsibility for representation of the Department of Family Services, now DSS, the data reflects a dramatic decline in the filing of abuse and neglect petitions by the Office of the County Attorney. In 2022, the Office of the County Attorney filed 77 petitions for abuse and neglect, and, as of June 18th, the Office of the County Attorney has filed 48 petitions for abuse and neglect in 2023. As of July 16th, 2023, approximately one (1) month later, the Office of the County Attorney had filed five (5) additional petitions covering two (2) actual families (each child constituting a separate petition, even if not separately written).

In comparison to DFS Legal's production in years prior to Covid-19, that represented a significant decline without any correlating decline in the number of hotline calls.[7] With respect to removals, the only publicly available data dates back to 2021 which indicated that thirteen (13) children were removed, and the Office of the County Attorney's office took over DFS Legal in

[5] Grand Jury Testimony of Witnesses 3, 4, 5, 6, 7, 11, 18.
[6] Id.
[7] Grand Jury Exhibit 89.

May of that year.[8] Publicly available statistics also show that as of December 31st, 2022, fifty-two (52) children are waiting to be freed for adoption and that 63.5% of those children were waiting to be freed for adoption for one (1) year or more.[9] One such child was placed into foster care, a petition to terminate the father's parental rights was filed in March of 2021, the County Attorney's Office filed a different petition in March of 2022 and then the child was not freed for adoption until June of 2023 because of delays from the County Attorney's Office.[10] Testimony from Witness 7 further supports these statistical findings as Witness 7 reported that in dealing with other counties around the state they wait approximately a week and a half for orders terminating parental rights which result in freeing children for adoption; yet, the wait time for Sullivan County is far greater. In one specific example they have waited for at least three (3) months. Delay in filing of these petitions leaves the children in Foster Care without the ability to be adopted, keeping them in Foster Care in perpetuity even if a family seeks adoption of the child.[11] Witness 19 testified the delays have a profound impact on the mental health of the children.

Testimony from numerous witnesses have described the relationship with the Office of the County Attorney as oppositional and difficult, and do not believe that the Office of the County Attorney's supervision of the Department of Social Services' legal work is in the best interest of either Sullivan County or our children.[12] The credible testimony and statistics indicate that the Office of the County Attorney's number of abuse and neglect cases and numbers of removals have not increased in comparison with DFS Legal and instead, these levels have suffered sharp decreases.

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[8] Grand Jury Exhibit 63.
[9] Grand Jury Exhibit 88.
[10] See Grand Jury Testimony of Witness 19.
[11] See Grand Jury Testimony of Witness 19.
[12] See Grand Jury Testimony of witnesses 2-7 & 10-13 & 17-19.

The closest available data provided by testimony from Foster Care Worker, Witness 19, and credited by the members of the grand jury showed that in 2022, fifteen (15) children entered care as a result of a removal and remained there by year end, and in 2023, up until July 28th, 2023, fourteen (14) children had entered care as a result of a removal and remained there as of that date.[13]

In comparison, DFS Legal in some cases more than doubled those numbers; in 2018, thirty-eight (38) children entered care as a result of a removal and remained there by year end; in 2019, thirty (30) children entered care as a result of a removal and remained there by year end; and in 2020, twenty-eight (28) children entered care as a result of a removal and remained there by year end.[14] The data is not reflective of children who were removed and returned to their homes or adopted prior to the end of the year.

[13] Grand Jury Exhibits 8 & 9.
[14] Grand Jury Exhibits 5-7.

3. Child Protective Services

CPS is obligated under New York State law to investigate allegations of child abuse[15] and/or maltreatment[16].[17] CPS receives reports of suspected child abuse, maltreatment, and/or neglect twenty-four (24) hours a day and seven (7) days a week through the State's Central Registry ("SCR").[18] The SCR is a centralized system which mandates that certain individuals under the law make reports of suspected abuse, maltreatment, and/or neglect, also referred to as mandated reporters.[19] After the report is made, a hotline report is generated and forwarded to the responsible county. Throughout regular business hours, between 9 a.m. and 5 p.m. a phone rings within Sullivan County CPS notifying employees of a hotline report. A caseworker or employee retrieves the hotline report and that report is then transferred to a caseworker. If the report comes in after normal business hours, a notification will go out to an on-call worker who is responsible for reviewing and investigating the hotline report after hours.

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[15] N.Y. FCA § 1012(e), stating that an abused child is "less than eighteen years of age whose parent or other person legally responsible for his care (i) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or (ii) creates or allows to be created a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or (iii) commits, or allows to be committed . . ." enumerated offenses of state or federal law.

[16] N.Y. FCA § 1012(f), stating that a "neglected child means a child less than eighteen years of age (i) whose physical, mental or emotional condition has been impaired or is imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care (A) in supplying the child with adequate food, clothing, shelter or education . . . or medical, dental, optometrical or surgical care, though financially able to do so or offered financial or other reasonable means to do so . . . (B) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that he loses self-control of his actions; or by any other acts of a similarly serious nature requiring the aid of the court; provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence establishing that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired . . . (ii) who has been abandoned . . . .".

[17] N.Y. SSL §424.

[18] N.Y. SSL §424(1).

[19] N.Y. SSL § 413.

After the case is received by CPS, the department has several responsibilities, they are required to make contact with the source of the report, the child, and initiate their investigation within twenty-four (24) hours of receiving the report.[20] Within seven (7) days of receiving the report, the department is required to perform a seven (7) day safety assessment.[21] This assessment requires a review of the investigative evidence gathered and a determination as to whether the department is going to take an administrative or legal action associated with their case.

Administrative action may involve the implementation of a safety plan. A safety plan is a voluntary, informal agreement between CPS and the subject of the report to take some kind of action, i.e. clean up a dirty home, provide for supervised visitation, attend drug and/or alcohol treatment, mental health treatment, provide the child with medical care, accept preventive services inside the home, etc. Safety plans are not court monitored unless ordered through the court and under the direction of DFS Legal were used as temporary solutions pending imminent court action because compliance was voluntary and failure to comply did not come with any consequences.[22] Upon filing a petition, Courts may order that these conditions are met and the respondent parent understands that failure to comply will result in a court response and also extend the amount of time for continued compliance beyond the sixty (60) days in which a case is open for a safety plan. These petitions cannot be filed without the assistance and approval of the Office of the County Attorney. This is supported by the credible testimony before the grand jury stating that all new court actions needed to be approved by the Office of the County Attorney prior to proceeding.[23] The party subject to a safety plan implemented by CPS without the assistance of the court can easily avoid compliance and would be free to leave the jurisdiction entirely with their child or

[20] N.Y. SSL §424(6)(a).
[21] N.Y. SSL §424(3).
[22] See Grand Jury Testimony of Witness 16.
[23] Grand Jury Exhibit 22.

children if they saw fit without any consequences. It is within the tradition of DFS Legal that safety plans are temporary solutions to allow time for filing of petitions, not meant as long term solutions.[24]

The types of legal actions that can be taken by the Office of the County Attorney on behalf of CPS include the filing of an abuse and/or neglect petition with the Sullivan County Family Court.[25] Within the confines of such petitions CPS through their legal representation can ask for multiple different forms of relief, including temporary orders of protection, court ordered services in the home, or an order requiring a screening (i.e. drug and/or alcohol) or assessment (i.e. medical).[26]

In addition to the different forms of relief mentioned, the petitioner, in this situation DSS, can ask for removal of the child from the home. The New York Family Court Act provides for three (3) different ways a child can be removed from the home. One of which is the removal of the child with the written consent of the parent or legally responsible party for the child.[27] Without the written consent of the parent or legally responsible party, the Family Court Act provides for two (2) options for removal and, between the two (2) options, the statutory criteria which must be satisfied are identical.

One of the options, carried out by the Commissioner of the Department of Social Services without the assistance of legal counsel, is limited to removing a child for no more than seventy-two (72) hours, and requires the subsequent filing of a petition for temporary removal within that time-frame.[28] This is known as an "emergency removal without a court order". Once this

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[24] See Grand Jury Testimony of Witness 16.
[25] N.Y. FCA § 1032.
[26] Grand Jury Exhibit 86.
[27] N.Y. FCA § 1021.
[28] N.Y. FCA § 1024.

procedure is implemented the Commissioner is required to seek a petition through his counsel, the County Attorney's Office. If a petition is not filed with the court by counsel then the child must be returned to their parent or party legally responsible for the child within the seventy-two (72) hour time-frame.[29]

If the aforementioned petition is filed with the court, the County Attorney's Office then must establish at an evidentiary fact-finding hearing before the Sullivan County Family Court that "the child appears [] to suffer from the abuse or neglect of his or her parent or other person legally responsible for his or her care [and] that his or her immediate removal is necessary to avoid imminent danger to the child's life or health . . . .".[30] Upon such a finding, temporary removal will be granted and ordered.

If the Commissioner or other authorized party does not exercise an emergency removal, and the parent or legally responsible party does not provide written consent for temporary removal then DSS can pursue the filing of a petition seeking a court order for a temporary removal of a child from the home.[31] In such a proceeding DSS still must show through their legal representation that "the child appears so to suffer from the abuse or neglect of his or her parent or other person legally responsible for his or her care that his or her immediate removal is necessary to avoid imminent danger to the child's life or health; and there [was] not enough time to file a petition and hold a preliminary hearing . . . .".[32] When a temporary order of removal is issued by the Family Court then a hearing will be scheduled to determine the legal justification for the removal the same

[29] N.Y. FCA § 1022.
[30] N.Y. FCA § 1022(a)(i)(B).
[31] N.Y. FCA § 1022(a)(i).
[32] Id.

day or, if after hours, the next day.[33] Both exercises of removal require intervention by the County Attorney's Office and without such intervention the child must be returned.

When investigating cases of suspected abuse and/or maltreatment to ultimately determine whether court intervention will be necessary, all caseworkers must document their investigative steps in a system referred to as Connections ("CONNX").[34] This includes notes related to interviews of subjects, family members, children, hospital staff, school staff, neighbors, etc. Notes are to be entered contemporaneously and not more than thirty (30) days after an event occurred.[35] All notes entered create a date and time stamp and can be modified by the caseworker up to fourteen (14) days after their entry into CONNX if any errors or omissions occurred in the entry. OCFS provides examples on how notes are to be entered into the system in their CPS Investigative Manual.[36] An investigation is comprehensive and may also involve retrieval and review of photographs, video, social media, medical records, school attendance records, treatment records, criminal history records, and any document deemed relevant to the investigation.

Within sixty (60) days of receiving the case for investigation, a caseworker must determine whether a case is indicated or unfounded. Although required, not every case will be indicated or unfounded within that timeframe and, instead, some cases will remain open for longer due to administrative or other reasons.[37]

For a caseworker to indicate a report they must determine that a "fair preponderance of evidence" exists to support the allegations in the hotline report. If a fair preponderance of evidence does not exist, the caseworker must unfound the hotline report.[38] Caseworkers are required to seek

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[33] N.Y. FCA § 1022(a)(ii).
[34] 18 NYCRR 428.5(c)(2).
[35] 18 NYCRR § 428.5.
[36] Grand Jury Exhibit 86.
[37] N.Y. SSL § 424(7).
[38] 18 NYCRR 432.2(b)(3)(iv).

review from their applicable supervisors prior to indicating or unfounding a case. If any questions or concerns regarding said determination remain, the CPS supervisor would raise those concerns up their chain of command to the Director of Child Protective Services and the Service Coordinator.[39]

An indicated report comes with legal consequences for the parent, guardian, caregiver, or subject of the report. One such consequence includes the limited availability of the contents of the report and investigation until the subject's youngest child reaches the age of twenty-eight (28) years old. Additionally, childcare agencies, foster care agencies, adoption agencies, may be informed of the report which, in turn, would affect the subject's ability to continue to work with children. If the report is not indicated, or an indicated report is subsequently overturned after a request for modification and/or fair hearing, the report could not be used to prevent these individuals from working in such agencies with children. In addition, the report is sealed and expunged ten (10) years after the receipt of the report.

If a case is indicated, the subject of the report will receive notice that CPS has indicated the report and they are given an opportunity to contest the finding within ninety (90) days of receiving notice of the CPS's decision. If an administrative review at OCFS does not subsequently amend said finding, the subject has a right to a "fair hearing" to determine the propriety of CPS's decision making.

At such time, a fair hearing would be scheduled and the Department's legal representation, in this case, the County Attorney's Office, would be tasked with appearing at the hearing and presenting evidence to meet their burden of proof, that is, to prove by a fair preponderance of the evidence that the subject "committed an act or acts of child abuse or maltreatment." A fair

[39] See Grand Jury Testimony of Witness 3.

preponderance of the evidence standard has been defined by OCFS as requiring CPS to "weigh the evidence of abuse or maltreatment in its totality to discern whether more evidence was gathered during the investigation to support the allegations than not [gathered]."[40] OCFS goes on to state and clarify that this standard of evidence "does not mean that there must be enough evidence for a criminal charge [, the reasonable cause standard,] to be brought or for a conviction [, the beyond a reasonable doubt standard,] to be made for the listed criminal offense."[41] If a representative from the County Attorney's Office does not appear, present evidence, or meet their statutory burden at the fair hearing the CPS finding would be overturned, sealed, and the report later expunged ten (10) years after the receipt of the report.

4. Multi-Disciplinary Team

Within DSS, as codified in the Social Services Law, is the establishment of a Multi-Disciplinary Teams ("MTD"). A MTD may contain representatives from the "child protective services, law enforcement, district attorney's office, physician or medical provider trained in forensic pediatrics, . . . [and other identified professions]."[42] The MTD's primary purpose is to investigate "reports of suspected child abuse or maltreatment"[43] and the team is designed to bridge the gap between civil investigations conducted by CPS caseworkers and criminal investigations conducted by members of law enforcement by encouraging information sharing across respective agencies.[44] It is within the discretion of the MTD as to types of cases of child abuse or maltreatment that will be investigated.

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[40] Grand Jury Exhibit 64; 18 NYCRR 434.10 stating that a fair preponderance of the evidence "is evidence that outweighs other evidence that is offered to oppose it."
[41] Id.
[42] N.Y. SSL § 423(b).
[43] Id.
[44] NY SSL § 423(6).

The MTD established within Sullivan County is known as the Family Violence Response Team ("FVRT") which is staffed with caseworkers from CPS, a caseworker from Preventive Services, an Investigator from the New York State Police, an investigator from the Sullivan County District Attorney's Office, and supervised by a Senior Investigator from the New York State Police. Generally, the FVRT takes cases involving allegations of sexual abuse or severe physical abuse and investigations conducted by this team can result in both civil and criminal action.

5. Preventive Services Unit

The Preventative Services Unit ("PSU") is a unit under DSS which has been designed to offer services to prevent children from being placed into Foster care. PSU provides services including, but not limited to, day care and/or child care, job training, educational services, mental health services, homemaker services, parent training or parent aide, clinical services, transportation, respite care and services, emergency twenty-four (24) hour services, cash assistance, and housing assistance. A CPS report alone, is insufficient for PSU to offer services to the subject of the report or their children. The services, nevertheless, can be voluntarily accepted by the parent or legally responsible party, or mandated by law or court order.[45] Services "must be provided when: [t]he child is at imminent risk of placement into foster care[46][,] [t]he child is at risk of re-placement into foster care[,] [t]he child may be returned to parent(s), relative(s), or legal guardian(s) ahead of schedule[,] [or] [t]he child has been placed in an Emergency Foster Family Boarding Home."[47] Further criteria must be considered when determining whether the services are mandated. If there is a belief by the caseworker that placement in Foster care may not be

[45] N.Y. SSL 409-a; 18 NYCRR § 430.9.
[46] The child is considered to be at imminent risk of placement when the health and safety of the child is at risk (must have an indicated CPS report), the parent fails to care for the child's home or indicated a desire to place the child in Foster Care, the Parent is unavailable to care for the child, the parent has a physical or mental condition that prevents them from caring for the child, the child has special needs that cannot be met in the home, and/or the parent has shown an inability to care for her child in utero. See 18 NYCRR 430.9(c).
[47] Grand Jury Exhibit 87.

immediate, and instead may be a long-term possibility, the services are not mandated but are provided to prevent the long-term possibility of the child into Foster Care.

Caseworkers will then monitor the subject's compliance with the services placed into the home. Caseworkers must maintain notes related to the services provided, document the subject's compliance, and their casework in the CONNX system.[48]

6. Foster Care Unit

The Foster Care Unit ("FCU") is another unit within the DSS matrix. FCU addresses areas such as home-finding, adoption, and placement in foster care for neglected, abused, and/or maltreated children. Foster care is residential placement for children outside of their home, which may include placement in private for-profit institutions, group homes, or in the privacy of private homes.

Placement into Foster Care is designed to be a temporary placement where, despite placement, the parent or other legally responsible party, retains parental rights of the subject child/children. This permits the legally responsible party to regain custody of the child/children upon a showing that said party has successfully *rehabilitated.* In the alternative, if the legally responsible party demonstrates they cannot be successfully rehabilitated, CPS and FCU will initiate a proceeding in the Family Court to terminate the parent's or other legally responsible party's parental rights, thereby legally freeing the child for adoption into a new home.[49]

The adoption caseworkers work with children who are legally freed for adoption, either through the consent of the parent or other legally responsible person or through court intervention

[48] Id. at 4-3.
[49] See Grand Jury Testimony of Witness 19.

after a proceeding approving for the termination of parental rights. These caseworkers then seek to have these children adopted by their foster parents or by locating another adoptive home.[50]

Children come into the Foster care system through a temporary removal pursuant to an emergency removal; through a request via an abuse or neglect petition, if the child is determined to be a Person in Need of Supervision under certain scenarios; or the child is voluntarily placed into foster care through a surrender by the parent or legally responsible person.[51]

Once a child is voluntarily placed into Foster care a petition for the termination of parental rights must be filed within twenty-nine (29) days of the voluntary placement agreement being signed.[52] If the petition is not filed, nor an order issued by the judge, there is no legal basis to hold the child in the Foster care system. Furthermore, until a petition for the termination of parental rights is filed, that child cannot be lawfully adopted.[53]

Foster care comes at a great cost to counties around the state. As a result of the costs associated with this care, the Federal Government has provided reimbursement for 50% of the funding to localities for the costs of providing foster care to children.[54] Not every child placed into care will be eligible for this funding, however, members of the FCU are tasked with compliance with federal regulations to secure this funding. This is done, in part, through their legal representation. If compliance is not timely, the county will not be able to seek reimbursement and will lose said funding.

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[50] See Grand Jury Testimony of Witness 13 & 19.
[51] See Grand Jury Testimony of Witness 16 & 19.
[52] Id.
[53] Id.
[54] Title IV-E of the Social Security Act, 42 U.S.C. §§671-679b.

7. Positive Toxicology Babies in Sullivan County

Sullivan County currently suffers from the highest number *per capita* of drug addicted babies in New York State. This is supported by the credible testimony of Witness 15 and by statistics which are kept by New York State. The statistics show that 57.1 out of every 1,000 babies born in Sullivan County are born positive for drugs or born with a Neonatal Abstinence Syndrome ("NAS") score. In Oswego County 45.9 out of every 1,000 babies are born positive for drugs or born with NAS. This represents the second highest number of cases in the state per capita however, Oswego is not a representative comparison because they have a much larger population than Sullivan County. In comparable counties with smaller populations such as Broome County, 31.9 out of every 1,000 babies are positive for drugs or born with NAS; and, in Erie County, 25.6 out of every 1,000 babies are born positive for drugs or born with NAS. When compared to these counties the disparities are quite significant and alarming.[55] It is believed that the actual numbers may be higher than reported because prior to November of 2021 women delivering a baby were universally screened in the hospital for substance abuse. Toxicology screens can be requested, but are no longer mandated pursuant to changes in the law.[56] The mother can now refuse the toxicology for herself and her baby even if the baby is suffering from withdrawal symptoms. The mother's refusal can only be overridden by two (2) physicians if they believe that the toxicology is medically necessary for treatment of the baby. However, this policy is not universally implemented by all hospitals in New York and has yet to be implemented in hospitals in Sullivan County.

A baby suffering from NAS suffers from the same withdrawal symptoms that an adult would suffer from. When an adult suffers from withdrawal they are typically sent to the Intensive

[55] Grand Jury Exhibit 49.
[56] See Grand Jury Testimony of Witness 15.

Care Unit for care and monitoring. The symptoms associated with withdrawal are elevated and uncontrolled temperatures, high fever, nausea, vomiting, and seizure activity. The symptoms vary depending upon when the substances are consumed. Drug use during the mother's first trimester generates worse long-term outcomes for babies related to development and developmental delays.[57] Drug use during the latter parts of the mother's pregnancy and closer to birth present stronger initial short-term withdrawal symptoms and medical problems after birth such as seizures, cardiac problems, gastro-intestinal problems, risk of stroke, intestinal inflammation, infection, and potential death.[58]

In 2019, Sullivan County began receiving CAPTA/CARA grant money from the State, which provides funding to localities if the locality identifies a need for the funding. Sullivan County's designation as the county with the highest level of NAS and positive toxicology babies *per capita* qualifies them for that funding. That funding is then provided to the locality to fund collaboration between public health nursing and CPS for cases involving child abuse related to substance abuse.

Any case meeting that criteria receives an automatic referral to public health nursing to minimize the impact on positive toxicology babies and their parents. This includes making sure the children are not continuing to withdraw after returning to the home, following the development of the children because these children have an increased likelihood of Attention Deficit Hyperactivity Disorder ("ADHD") and developmental delays, and ensuring that the parents are following up with the pediatrician.[59] There are currently seven (7) public health nurses employed by Sullivan County managing two-hundred and six (206) cases.[60] Two of the nurses are dedicated

[57] See Grand Jury Testimony of Witness 15.
[58] Id.
[59] Id.
[60] Id.

to maternal child health and the remaining staff are reserved for the adult population. At one point the county staffed twenty-seven (27) public health nurses for a caseload of one-hundred and fifty (150) cases and the staff is now down to seven (7) managing a larger case load of two-hundred and six (206) cases.

8. Use of Hotels as Temporary Housing for those Suffering from Substance Abuse

Women and other individuals suffering from substance abuse disorder are generally found to be homeless or have inadequate shelter or living situations. Sullivan County currently places these individuals into motels as part of emergency housing. These are the same motels that incarcerated individuals are released to, individuals in some circumstances that were charged and convicted of selling narcotics, and the same motels where substance abuse is rampant.

Sending mothers and their positive toxicology babies to sleep in rooms right next door to their drug dealers in some instances is not setting up the mother and the baby for success. In addition, the infrastructure inside of the motel is not suitable for raising a newborn. The motel rooms contain a small sink, a shower, a microwave, and are often unsanitary.

Sullivan County currently possesses architectural plans to build a shelter; however, the shelter has not been funded or built.

B. Impetus for the Grand Jury Investigation[61]

Police Officer 1 testified that on May 2nd, 2023, Police Officer 1, of the Village of Liberty Police Department received a call from the Liberty Police dispatch informing him that a child was seriously injured and could die at the Knights Inn Motel. As a result, Police Officer 1 responded to the Knights Inn Motel, located on State Route 52 in the Village of Liberty, Sullivan County, New York. Upon arriving on scene, Police Officer 1 observed the parents to be visibly upset and

[61] See Grand Jury Testimony of Witnesses 1-20.

inconsolable. The child had been transported via ambulance with a Liberty Police Officer to continue medical efforts to revive the child. Unfortunately, the child, sixteen (16) month old A.L. passed away due to an apparent overdose of fentanyl combined with xylazine. Police Office 1 subsequently learned that a member of CPS conducted a home-visit for A.L. earlier that evening.

Police Officer 2 testified that on May 2nd, 2023, he received a call while at his place of residence to return to work to investigate a sixteen-month (16) old cardiac arrest. Police Officer 2 arrived at the Knights Inn Motel and spoke with police on scene who advised him that when they arrived the child's mother and the father were in the lobby of the Knights Inn with an unresponsive sixteen-month (16) old child. Police Officer 2 learned that the father was sleeping in the hotel room when the sixteen-month (16) old child became unresponsive. Police Officer 2 observed a tin foil wrapper with residue on the floor of the hotel room as well as a metal pipe commonly used to smoke narcotics. The items were forensically analyzed and the analysis alleges that both items contained the DNA of the child, A.L.

As part of the Liberty Police Department's investigation surrounding the circumstances of the child's death, the Liberty Police Department subpoenaed CPS records from the Department of Social Services surrounding reports and/or investigations related to A.L. and their younger sibling, C.L.

The records were returned to Police Officer 2 and a review of the records revealed that CPS made three (3) separate requests on different dates and times to the County Attorney's Office to remove A.L., and two (2) requests to remove C.L. from the home and each request was denied by the Office of the County Attorney.

Based upon the facts and circumstances documented in the CPS investigation and the significant rate of positive toxicology babies born in Sullivan County it was incumbent upon law

enforcement and the District Attorney's Office to determine the basis for the decision to deny the requests for removal and whether the death of A.L. could have been prevented.

III. GENERAL CONDUCT

A. Timely Filings

1. CPS Investigation of P[62]

This case involved the removal of multiple children from their mother and placed with their maternal grandmother in 2017 but returned to their mother as a result of the grandmother's death and CPS's lack of awareness, is discussed in more detail in section (C)(3)(A). The allegations against the mother were primarily based on substantial drug abuse.

On March 17, 2023, the Department asked the Office of the County Attorney to file a removal petition. The Office of the County Attorney refused to file a removal petition; however, they did agree to file a petition for services. Despite the caseworker's multiple attempts to check on the status of the petition, the Office of the County Attorney neither responded to the communications nor filed a petition. As of April 19, 2023, the Office of the County Attorney had not filed a petition.

The members of the grand jury find Witness 10's testimony credible and further find that the Office of the County Attorney breached an ethical duty to provide diligent representation to their client by failing to file the petition, in addition to prejudicing the client, the failure to file the petition endangered the children and placed them at unnecessary risk.

2. Two Unnamed Educational Neglect Investigations[63]

On July 5, 2023, the Office of the County Attorney agreed to file two (2) separate petitions alleging educational neglect for two (2) separate families, one for Family Y and one for Family Z. The allegation involved an educational neglect petition alleging that the children have missed too much school as a result of parental actions.

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[62] Witness 10; Exhibit 36.
[63] Grand Jury Testimony of Witness 8.

As of August, the petitions had still not been filed. The caseworker found this delay unacceptable given that the new school year was very near to starting and no work had been done to correct the parents' behavior which was negatively affecting the children's education.

The members of the grand jury find Witness 8's testimony credible and further find that the Office of the County Attorney breached an ethical duty to provide diligent representation to their client by failing to file the petition in addition to prejudicing the client, the failure to file the petition is negatively impacting the children's education which is in direct contradiction with the client's interests in protecting the children.

3. CPS Investigation of Q.[64]

This Family has a long and complex history which involved both the father's domestic violence, abuse of the mother and the father's sexual abuse of the children which resulted in the voluntary rehoming of over half a dozen of their children with written "legal guardianship consents," custody agreements, in 2020. The mother filed a sworn family offense petition containing the domestic violence allegations, left the father, and kept custody of two (2) children.

On May 4, 2022, the Court asked CPS for a report because the mother had asked, as part of the father's custody petition, to move back in with the father and the multiple children who had been living with other families for over two (2) years. CPS assigned a caseworker who commenced an investigation.

The children nearly all agreed with the state of affairs that had existed in the home before they were sent to live with other families. The father was violent and controlling. He used mouth pulling as a punishment, where he would pull their mouths open for so long it would take time for their jaws to go back to working normally. On one (1) occasion the father had hit a child on the

[64] Grand Jury Testimony of Witness 10; Grand Jury Exhibit 37.

head with the stick of a broom to the point that he was afraid he would get in trouble if the child were taken to the hospital; as a result, the child bled through their pillow. The father likely sexually abused the mentally disabled child. He would get in bed with that child and the other children could hear the child grunting or screaming through the wall or from the other side of the same room.

The children reacted with extreme and visible fear at the prospect of being sent back to live with their father. The mentally disabled child had a mental breakdown requiring hospitalization in a psychiatric hospital, and the mother had coached the child as to what to tell CPS.

On May 18, 2022, CPS requested the Office of the County Attorney file a petition for removal of all of the mother's children; this would remove the last two (2) children from the mother and get a court order placing all of the other children with their individual rehoming families. The Office of the County Attorney agreed to file the petition.

The caseworker sent the update requested by the court on May 19, 2022. The petition had not been drafted yet. The caseworker followed up with the Office of the County Attorney on May 20, 2022, and they were still planning to file the petition.

Some time went by and the mother picked up the child from the psychiatric hospital – the custody agreements had not removed legal custody from the mother and so there was nothing stopping the mother from picking up the children if she wanted. One (1) of the families had obtained a temporary restraining order preventing the mother from picking up the child for whom they were providing care. The mother went to kidnap that child on June 9th. She took the mentally disabled child and the two (2) children she still had custody of and kidnapped that child with the assistance of candy as bait. The mother intended to kidnap a second (2) child but did not know where they were living. The mother was arrested. The other families were very concerned and

tried unsuccessfully to get similar restraining orders to prevent the mother from regaining custody of the children.

On June 10, 2022, the caseworker contacted the Office of the County Attorney to ask for an update on the petition and the office questioned how there had been a kidnapping without a custody order and asked to meet the next week to assess the case. The caseworker found this odd because the Office of the County Attorney had been told about the custody agreements and they had already agreed to file a petition. The caseworker met the next week with the Office of the County Attorney as requested. The Office asked the caseworker to leave the file to look through and see if there was something that could form the basis of a petition.

As of testimony, over a year had passed without any follow-up from the Office of the County Attorney, who still has her file.

The caseworker testified that the delay of over a year is unacceptable particularly where the danger to the children is that at any point in time they could be returned to the household where the father lives with the mother. The records received by the caseworker showed that the father had discontinued mental health treatment after disagreeing with his diagnosis of narcissist personality disorder, issues with anger management, and intermittent explosive disorder. The father had admitted to previous sexual touching of an unrelated child. The caseworker believed that the return of the children could have been affirmatively damaging to the children given the way they reacted to the thought of being returned home.

The members of the grand jury find Witness 10's testimony credible and further find that the Office of the County Attorney breached a duty of diligent representation by neglecting the legal matter. The Office of the County Attorney has placed those children at perpetual risk of being sent back to a father who allegedly struck a child so hard with a broom that the child bled

through the pillow and did not transport the child to the hospital to receive necessary medical treatment, and who has admitted to perpetrating sexual acts against a child.

B. Conduct Related to a Refusal to File

1. Derivative Neglect

Family Court Act § 1046 (a) (i) provides that "proof of the abuse or neglect of one child shall be admissible evidence on the issue of the abuse or neglect of any other child of, or the legal responsibility of, the respondent." However, this such evidence may not provide the sole basis for a final determination of derivative neglect unless the parent's past conduct demonstrates fundamental flaws in the parents' understanding of the duties of parenthood, flaws that are so profound as to place any child in his or her care at substantial risk of harm. Where this is established by a preponderance of the evidence, a finding of derivative neglect is appropriate.

a. CPS Investigation of E.[65]

As discussed in detail in section (C)(2)(a) related to positive toxicology children, at the birth of the child E-2. CPS requested a removal based on derivative neglect given the child's positive toxicology and the previous removal of the older sibling for parental drug use and a positive toxicology at birth. The caseworker had been able to determine that the mother's circumstances had not changed and that E-2 was equally as at risk as the older, unreturned, sibling. The Office of the County Attorney refused this petition, stating that a safety plan and order of protection would be sufficient to protect E-2.

The members of the grand jury find the witness' testimony credible and further find the Office of the County Attorney's assessment that the mother was not an imminent risk to the child

[65] Grand Jury Testimony of Witness 5, 6, 16; Grand Jury Testimony of Exhibit 27, 94, 33.

incorrect. The Office of the County Attorney's failure to take legal action placed the child at unnecessary risk of harm.

b. CPS Investigation of L.[66]

A hotline report came in and Witness 7 was assigned to the case. Witness 7 learned that the baby was born in the backseat of a Jeep, the mother had a low I.Q. and was not mentally capable of taking care of the baby. During childbirth the baby was dropped and hit their head on the floor of the Jeep. The baby was brought to St. Luke's hospital and placed into the NICU because the physician was concerned about the shape of the baby's head likely caused from being dropped in the Jeep.

The mother had two (2) previous children removed through a neglect petition in Sullivan County for her failure to care for her children due to the low level of her I.Q.

Witness 7 interviewed the mother and she stated that she previously told a caseworker that she did not know when to feed the baby, but the baby would tell her when to feed the baby. Witness 7 explained that the mother did not demonstrate an ability and understanding of how to parent the baby. The mother initially planned to have the child go to the maternal grandmother, however, Witness 7 and CPS did not feel that was appropriate because the maternal grandmother had previously attempted to become a foster parent and was found to be unfit. In addition, the mother would be living with the maternal grandmother giving de-facto custody of the child back to the mother.

At the family review meeting Witness 7 requested a removal of the child pursuant to derivative neglect, the Office of the County Attorney stated that derivative neglect no longer exists because the child must have been born at the time of the original neglect proceedings for the other

[66] Witness 7, 16; Exhibit 31.

children. However, the Office of the County Attorney agreed to write the petition on other grounds despite at the time that the child was ready to be discharged from the NICU and the petition had not yet been drafted.

Witness 7 contacted the Office of the County Attorney via telephone and informed them that the petition for removal should be filed imminently and the baby should not be discharged to the mother. The Office of the County Attorney stated in this conversation that there would be no harm in the baby going home with the mother overnight. Witness 7 was concerned with that statement because one (1) night would turn into one (1) day, one (1) month, and one (1) year.

The petition was drafted by the County Attorney's Office.

After a review of the CONNX progress notes, the Office of the County Attorney in speaking to Witness 7 directed Witness 7 to alter a case note previously entered by Witness 7. Witness 7 did not alter the case note as requested. In said note, Witness 7 documented statements between the mother and the grandmother of the child and the statements were conflicting. The Office of the County Attorney requested that the conflicting statements be removed and Witness 7 only enter into the notes what CPS knew to be true. The notes are expected to reflect the reality of events as they occurred. Conceding to alter the note would have been a violation of CPS policy and Witness 7 did not alter the note as requested by the Office of the County Attorney. Witness 7 informed the Office of the County Attorney that it was against CPS policy to do so and the Office of the County Attorney responded it should be done.

The members of the grand jury find that the credible testimony of Witness 7 demonstrated conduct incompatible with the ethical practice of law.

Furthermore, the credible testimony demonstrated the Office of the County Attorney's lack of understanding of the derivative neglect statute particularly where the court eventually made a

finding that the mother had derivatively neglected the newborn baby and the baby was removed, all despite the Office of the County Attorney's assertions that derivative neglect could not be used in this case.

c. CPS Investigation of R.[67]

On May 6th, 2022, a hotline report was received with allegations that the mother, known to the mandated report to have a history with CPS and ongoing mental health concerns, had given birth to another child who arrived 6 weeks early. The same caseworker was assigned and commenced an investigation.[68]

The mother had a history with the Department; having previously given birth to a premature child on August 12th, 2019. The child stayed in the NICU until discharged to the mother on September 17th. On September 26th, less than 10 days later, a visiting nurse, one of the mother's service providers, arrived at the mother's home for a scheduled visit to find the 6-week-old (6) child struggling to breathe, cold to the touch, rigid, and lethargic. The nurse called 911. The mother had tried to cancel the nurse's visit as she was arriving, and the nurse had to convince the mother to go to the hospital with the child.

At the hospital it was determined that the child had multiple injuries of multiple ages and at various stages of healing. Some of the injuries included fractures of the skull, ribs, and femur, lacerations to the liver, retinal hemorrhage, and a brain bleed. The child had been in the mother's care for less than ten (10) days. The mother lied and changed her story when confronted as to the nature of the child's injuries. The mother even attempted to get a service provider to lie on her behalf to state that the child's older sibling had hit the injured child with a toy truck causing the injuries in the provider's presence.

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[67] Witness 10, 15, 16; Exhibit 38.
[68] See Grand Jury Testimony of Witness 10; Witness 15; Witness 16; Grand Jury Exhibit 38.

The mother eventually admitted, as part of the resulting criminal interview, that she had squeezed the child's ribs and attempted to drop the child, face first into the bassinet because the child would not stop crying. The mother missed the bassinet and actually dropped the child onto the concrete floor, she stated she had done this intentionally. The mother had no understanding of the impact her actions had on the injured child. A petition was filed and the Family Court Granted the removal of the child, placed the child into foster care along with an eleven (11)-month-old sibling, and did not permit any visitation.

The mother was prosecuted for reckless assault of a child, pled guilty, and was sentenced to probation on the condition that she surrender her parental rights. At the time her third child was born, the mother was still on criminal probation, through 2026, for the injuries she caused to the second child. The mother did complete anger management and was attending 60% of her mental health treatment appointments, enough to avoid being discharged. She did not follow through with a recommendation for psychiatric treatment. The mother stated to her probation officer that she hoped she did not hurt this one. The nature of the mother's concern was only her worry about being sent to jail if she did. Mental health providers diagnosed her with a low I.Q. (60), impulse control, and worried that she might act impulsively again if presented with a noncompliant child. Providers were of the opinion that the mother had very limited insight and difficulty predicting the future. One provider was of the opinion that she was only presently compliant with services to have the baby returned and would discontinue services if the child were returned.

The mother delivered this third child by cesarean section and would be the sole caregiver as the father was in prison in Virginia. The mother had expressed feeling depressed and overwhelmed. The caseworker had the mother agree to a safety plan where the person caring for

the child's two (2) older siblings would also care for the third. The caseworker anticipated that person would file a custody petition.

On May 18, 2022, CPS asked the Office of the County Attorney to file a derivative removal petition asking whether they should ask for a three (3)-day consent or enter a safety plan giving care of the child to a relative until a petition could be filed. The Office of the County Attorney asked that a safety plan be instituted with the relative to allow for more time to draft the petition. Without providing justification, after the approval, the Office of the County Attorney withdrew their consent to file a removal petition. CPS met with the Office of the County Attorney again on May 24th, and the Office of the County Attorney continued their refusal to file a removal petition, instead suggesting a safety plan, services, and a psychological evaluation of the mother. CPS met again with the Office of the County Attorney on June 20th to no avail.

At the caseworker's prior suggestion a relative had already filed for custody. As part of that custody petition, the caseworker provided in-depth updates to the court. The court added CPS as an interested party on the relative's custody petition, granted the relative custody, formalized the safety plan, refused to grant the mother any unsupervised contact with the child – specifically ordering that the relative must be able to see and hear the mother at all times, and that not even a quick run to the car would be acceptable.

Lacking a petition, the caseworker closed the case and their progress notes end with the statement "[the mother] has not addressed the contributing factors which led to her purposely harming her newborn baby", the members of the grand jury agree.

The members of the grand jury find Witness 10's testimony credible and further find the Office of the County Attorney's assessment that the mother was not an imminent risk to the child shocking. The grand jurors findings are confirmed by the court's assessment that the mother

should not be permitted any supervised visitation, even for a moment. The Office of the County Attorney's failure to take legal action placed the child at unnecessary risk of harm.

d. Matter of Aiden L.L., 166 AD3d 1413 (3d Dept 2018)[69]

On April 14, 2017, the Family Court entered an order granting CPS's petition for removal of two (2) children. One was removed and found to have been neglected and the second was removed and found, by the Family Court, to have been derivatively neglected. An appeal was taken and the Appellate Division, Third Department, ultimately affirmed both removals and findings.

The members of the grand jury find that this case illustrates anappropriate use of derivative neglect to protect then-existing children and the Office of the County Attorney has failed to use the standard for the protection of children under similar circumstances and that failure represents conduct that needlessly introduces children into dangerous homes.

e. CPS Investigation into W.[70]

As discussed fully below in section (C)(2)(e), the removal of the first-born child on December 10, 2022, based on the mother's drug use preceded the second child's birth on or about February 26, 2023.[71] The second child experienced NAS symptoms at birth. Neither the mother nor the child were tested for the presence of illegal substances in their system at birth due to the mother's repeated refusal to consent.

The Office of the County Attorney referred to the second child's circumstances as a "classic case of derivative" neglect and willingly filed a petition dated March 9, 2023 alleging derivative neglect by the mother of the second child. Specifically the petition states:

> The child should be removed from Respondent [mother], pursuant to § 1027 of the Family Court Act in order to avoid imminent risk to the child's life or health because of the mother's continued and unresolved abuse of illegal drugs and failure

[69] Exhibit 67; Witness 16.
[70] Witness 11, 8; Exhibit 46.
[71] Grand Jury Testimony Witness 11; Grand Jury Exhibit 46.

> to make significant progress with Court ordered treatment. [The mother] has admitted to using drugs and alcohol on the same day that she gave birth to [the child]. [The mother] has not followed through with the substance abuse and mental health recommendations made by Lexington Center for Recovery.

The members of the grand jury find that this case illustrates that the Office of the County Attorney knew what derivative neglect was and how it could be appropriately used to protect after-born children. Therefore, the Office of the County Attorney's pattern of failure to use derivative neglect in similar cases breaches their duty of providing their client with competent representation and has endangered the safety of the children of Sullivan County.

2. Conduct Related to Positive Toxicology Babies

a. CPS Investigation into the Matter of E.[72]

On July 13th, 2020, while under the supervision of DFS Legal, CPS received a hotline report alleging that the mother had tested positive for marijuana and the child's, E-1, toxicology was pending.[73] It was later confirmed that the child's urine also tested positive for marijuana. The CPS investigation revealed that the mother had two (2) previous children removed from the home for drug related circumstances, she was not compliant with drug treatment, and the children had never returned to the mother.[74] In an interview of the mother she revealed that she had been smoking marijuana to control her nausea during the pregnancy. After the child was discharged from the hospital members of the Sullivan County Probation Department entered the mother's home and discovered white powder on a glass table together with baggies and a straw indicative of drug use. Caseworker, Witness 5, testified that CPS requested that the Office of the County Attorney file a neglect petition pursuant to the legal theory of derivative neglect because the

[72] Grand Jury Testimony of Witness 5, 6, 16; Grand Jury Testimony of Exhibit 27, 94, 33.
[73] Grand Jury Exhibit 33.
[74] Id.

mother's conduct had not changed, and the petition was filed by DFS-Legal pursuant to that theory. The mother thereafter consented to the application and her third child was removed from the home.

On March 4th, 2022, the SCR received a hotline report alleging that the mother had a child, E-2, and the mother's toxicology came back positive for opioids and marijuana at the time of her delivery.[75] Additionally, the child was born four-weeks (4) early, experienced withdrawal symptoms such as shaking, tremors, and had trouble feeding. The report further indicated that the mother had two (2) children removed previously, had a history of abusing illicit substances, and the two (2) previous children were never returned to her custody for failure to comply with drug treatment.[76] The mother again alleged that she used marijuana during her pregnancy to control her nausea symptoms and that she does not use opioids. She further argued that the marijuana she consumed must have been laced with an opioid substance. The mother also informed the CPS caseworker that she intended on permitting visitation from the father.

This was of concern to CPS because of a previous history of domestic violence (one such incident the father attempted to strike the mother and instead hit the eleven [11] day old child) that was a contributing factor in prior requests for removal. The caseworker consulted with the Office of the County Attorney via email on March 8th, 2022[77] and the Office of the County Attorney stated that CPS did not have enough for an emergency removal and the plan would be to file a neglect petition.[78] The case worker requested and received several reports of domestic disputes between the mother and the father and the reports also documented two (2) overdoses occurring within the last year at the residence. The Caseworker unsubstantiated the case on June 13th, 2022, the Office of the County Attorney refused to file a petition and due to the lack of negative impact

[75] Id.
[76] Id.
[77] Grand Jury Exhibit 27.
[78] Grand Jury Exhibit 33.

on the child and the mother appeared compliant with public health nursing and drug treatment programs and no legal action was taken.

Just six (6) months after the Office of the County Attorney's refusal to remove the child, on September 20th, 2022, SCR received a hotline report stating that the mother became impaired on heroin while caring for her six-month old child and was impaired to the extent that she had to administer herself Narcan.[79] CPS assigned Witness 5 to the case and met with the mother who admitted to overdosing on heroin and excessive drinking, twelve (12) beers a day. Witness 5 learned that the mother continued her non-compliance with drug treatment and CPS, therefore, requested that the Office of the County Attorney file a derivative neglect petition for removal of the six-month old child. The Office of the County Attorney refused to file the petition stating that the safety plan was protecting the child, derivative neglect was not an option and the petition could not be filed because the finding of neglect for the child born in July of 2020 was more than six (6) months old and could not form a basis for derivative neglect.[80] The safety plan required the mother to go to drug and alcohol treatment, to comply with preventive services, and the child was to stay with a relative. This safety plan did not prevent the mother from taking the child at any time and leaving the jurisdiction with continued custody of the child.

Subsequent to the institution of the safety plan, Witness 5 testified that the mother was non-compliant with treatment recommendations and, again, asked the Office of the County Attorney to remove the child from the mother's custody pursuant to derivative neglect. The Office of the County Attorney again refused to file a petition to remove the child despite her drug history, prior removals of two (2) children, and use of fentanyl to the point of impairment and near overdose in the presence of the child..

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[79] Id.
[80] Id.

Witness 5 testified that their continued frustration with the Office of the County Attorney and their inability to present cases in court despite repeated requests led to their departure from CPS.

After Witness 5 terminated their employment with CPS a new caseworker was assigned to the case. The mother continued non-compliance with substance use treatment and did not comply with preventive services. A neglect petition was filed with the consent of the Office of the County Attorney and on March 20th, 2023, the mother consented to the removal of the child. On April 3rd, 2023, the case worker indicated the case for inadequate guardianship and the mother's drug alcohol misuse, and the case remained open.

The members of the grand jury credit Witness 5's testimony and agree with Witness 5 that a neglect petition should have been filed for the child born on or about March 4th, 2022. The mother had a demonstrated history of drug abuse, had two children previously removed for the same or similar circumstances, and leaving the child in the home for an extensive period of time when the mother was impaired on heroin to the extent that she had to administer Narcan on herself placed the child at a grave risk to the child's health and safety.

The mother's prior conduct evidenced an inability to care for the newborn child and the mother's pattern of drug abuse had not changed at the time of the baby's birth. The grave risk to the child that the Office of the County Attorney failed to appreciate was demonstrated when a new report came into the SCR stating that the mother overdosed on fentanyl while the baby was present in the home. Even after the overdose, the Office of the County Attorney continued to roll the proverbial dice with this child's safety by failing to remove the child from the home.

Moreover, the grand jury finds that this case demonstrates the inability of safety plans to keep the children of Sullivan County safe and the need for filing of neglect petitions for the

circumstances described herein and similar conduct. Safety plans only require voluntary compliance and are entirely unenforceable after the case is closed within sixty (60) days, which is an inadequate timeframe to monitor safety compliance for children with seriously drug addicted parents.

b. *CPS Investigation of G.*[81]

On or about July 15th, 2022, the SCR received a hotline report stating that the mother gave birth to a premature child thirty-four (34) weeks old who was positive for cocaine and heroin. The mother abused heroin and cocaine on a daily basis and throughout the duration of her pregnancy. This included the mother ingesting cocaine and heroin intravenously and the day prior to the child's birth.[82] CPS conducted an investigation which revealed that the mother was in fact homeless, and the baby was transferred to the NICU suffering from NAS with scores ranging from 7 to 22. The baby's symptoms included tremors, irritability, crying, and the baby had a high pitch tone. When observing the mother with the baby she had no affect towards the child and displayed no emotions whatsoever while the baby struggled with withdrawal in the NICU.[83]

On July 15th, 2022, Witness 6 contacted the Office of the County Attorney and informed them about the nature of the case and the information obtained by the caseworker. On July 18th, 2022, the caseworker emailed the Office of the County Attorney an update regarding the case and informed the Office of the County Attorney that the caseworker could not locate the parents, and discovered that the parents had not visited their newborn child. As result of all of the circumstances CPS would be requesting that the Office of the County Attorney file a neglect petition against the mother.[84]

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[81] Witness 6; Exhibit 24.
[82] Grand Jury Exhibit 24.
[83] Id.
[84] Id.

On July 18th, 2022, the caseworker and Witness 6 attended the family review panel meeting with an attorney with the county attorney's office present. In addition to documented notes, Witness 6 testified that Witness 6 and the caseworker requested a neglect petition be filed for the removal of the child. All of the facts and circumstances were presented to the attorney and after consultation the attorney concluded that a neglect petition should be filed.[85]

On July 27th, 2022, the caseworker followed up with an attorney with the County Attorney's Office regarding the status of a neglect petition and the attorney responded that they would be conferencing the case prior to lunch.[86] One day later, on July 28th, 2022, the caseworker followed up with the attorney and the Office of the County Attorney via email stating that a meeting was scheduled by the County Attorney's Office to meet with the attorney at 2:30 p.m. to draft the neglect petition, but the meeting was canceled and the caseworker requested that the meeting be rescheduled.[87] On July 29th, 2022, the Office of the County Attorney requested that the documents be sent to a different attorney to draft the petition and the caseworker sent the documents to that attorney in an email later that day.[88]

On August 3rd, 2022, the Office of the County Attorney informed a CPS supervisor that they were preparing the petition, but did not believe a removal would meet the legal threshold because the safety plan was not instituted because the child was still in the NICU and requested more information to support reasonable efforts being made prior to the request for removal.[89] The caseworker responded in an email to the Office of the County Attorney stating that CPS wanted

[85] Id.
[86] Grand Jury Exhibit 24.
[87] Id.
[88] Id.
[89] Id.

the parents held accountable for their drug use during the pregnancy and continued use after the infant's birth.[90]

On September 2nd, 2022, after several communications with the Office of the County Attorney and legal, CPS indicated the case for inadequate guardianship against the father and mother and also indicated the allegations of drug/alcohol misuse against the mother. The inaction by the Office of the County Attorney left the mother without supervision or the requirement to continue treatment or services after the case concluded.

The members of the grand jury find the testimony of Witness 6 to be credible and further find the Office of the County Attorney's legal assessment to be focused on the outcome of the petition and not on making an aggressive legal argument to protect the children of Sullivan County. The Office of the County Attorney's focus on winning or winners and losers is the assessment left to the discretion of a judge, not any one representing their client. Furthermore, the Office of the County Attorney's legal practices are inconsistent with past DFS Legal precedent which the members of the grand jury find best protected the children of Sullivan County. By failing to file the neglect petition the Office of the County Attorney placed the child in imminent risk of danger to their life and safety.

c. CPS Investigation of K.[91]

On or about September 26th, 2021, the SCR received a report alleging that the mother gave birth to a child who was positive for marijuana.[92] The on-call worker assigned discovered that the child was transferred to St. Luke's hospital NICU for respiratory distress. The case worker, Witness 12, continued the investigation which revealed that the baby's meconium tested positive

[90] Grand Jury Exhibit 24.
[91] Witness 12, 6; Exhibit 28.
[92] Grand Jury Exhibit 28.

for opiates and the baby was diagnosed with NAS and in utero drug exposure.[93] The Doctor for the child represented to Witness 12 that the level of opiates found in the meconium was high and meant that the mother took more than one pill on several occasions after being twenty (20) weeks pregnant with the baby.

On October 5th, 2021, Witness 12 had a face to face legal consultation with the Office of the County Attorney requesting a removal of the child.[94] After consulting with the Office of the County Attorney, the Office of the County Attorney denied the removal request stating that the substance was only marijuana. Subsequent to the consultation with the Office of the County Attorney the child's meconium tested positive for opiates and after informing the Office of the County Attorney they requested additional updates on the baby's condition. The Office of the County Attorney was given updates on the baby's condition showing the baby's NAS score continued to increase. At that time, the Office of the County Attorney agreed to file a neglect petition and Witness 12 testified that CPS requested a neglect petition seeking removal of the baby with custody going to a relative.

The Office of the County Attorney prepared the petition for neglect and Witness 12 testified that they were asked to sign the petition for neglect. Upon arriving to sign the petition, Witness 12 was only permitted to review the signature page and not the entire document. Witness 12 testified that after receiving the entire petition Witness 12 realized that the wrong petition had been filed by the Office of the County Attorney because the petition requested an emergency removal hearing the baby had already been removed. Witness 12 contacted a supervisor to inform the Office of the County Attorney of the errors in the petition. Witness 12 and their supervisor called the Office of the County Attorney and placed the phone call on speaker phone.

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[93] Id.
[94] Id.

The petition was withdrawn and refiled for removal. Prior to the hearing for removal, Witness 12 informed the County Attorney's Office that they were concerned the father was using drugs, including cocaine. Witness 12 had attempted to receive the information over the phone, but the treatment provider would not provide the records over the phone without a subpoena. As a result, Witness 12 requested that the County Attorney's Office submit a subpoena for the records, however, the County Attorney's Office denied Witness 12's request and stated that the subpoena was not necessary. At the hearing for removal, the Judge requested treatment records for the father that CPS could not provide because of the Office's failure to draft the subpoena requested. Without the benefit of the information the Judge provided the father with temporary custody of the baby. Subsequent to the hearing, Witness 12 received the records which showed that the father had tested positive for alcohol and cocaine. If the court had that information at the time of the hearing it is likely that the court would not have granted the father temporary custody of the baby.

The grand jury finds the testimony of Witness 12 to be credible and the County Attorney's Office failure to provide diligent representation to their client by drafting a subpoena placed custody with the father who was abusing cocaine and unnecessarily placed the child at risk of harm.

d. CPS Investigation of W.[95]

On November 19th, 2022, the SCR received an anonymous report alleging that the mother's current drug use seriously affects her ability to care for her one (1) year old child. In sum and substance, the report alleged that the mother was up for days using crack to the point of impairment as the sole caregiver of her child, had expressed hope that the child died, previously assaulted the child's father fracturing his ribs in the presence of the child, and drug dealers were

[95] Exhibit 46. Witness 11, 8, 16.

in and out of the home.[96] CPS assigned Witness 11 to the case. Prior to interviewing the mother, Witness 11 learned that the mother's previous children had been removed from the home because of the mother's drug use and the mother's mental health issues.

Witness 11 went to the mother's residence on December 5th, 2022, and observed the mother slurring her speech, struggling to hold her head up, continually rubbing her eyes, to have dark bags under her eyes, enlarged pupils, and red and bloodshot eyes.[97] As a result, Witness 11 suspected that the mother had been using and was under the influence of drugs at the time of the interview. While present at the home, Witness 11 also observed a sober white male caring for the mother's child, a half naked male alleged to be her cousin exit the bathroom and upon entry into the bedroom another male was observed laying on the mother's bed where the crib was also located.[98] After leaving the residence Witness 11 expressed these concerns directly to the Office of the County Attorney and Witness 11 was informed that nothing could be done because the unknown sober white male was present in the home with the mother.[99]

Witness 11 returned to the home and entered into a verbal safety plan because the mother refused to agree to the written safety plan. The safety plan required the mother to remain sober and agree to public health nursing. After entering the agreement Witness 11 left the home.

On December 8th, 2022, just three (3) days after the Office of the County Attorney's failure to take any action, the mother reported that she and her cousin had a fight inside of the residence and he cut her with a knife, there was blood all over the residence, and she did not report the case to the police because she feared CPS involvement.[100] A police investigation ensued and the police

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[96] Grand Jury Exhibit 46.
[97] Id.
[98] Id.
[99] See Grand Jury Testimony of Witness 11.
[100] Id.

informed Witness 11 that the mother was the aggressor and likely to be arrested for stabbing the male in her home. Photographs were taken of the mother's residence and there was blood all over the house including the counter, the child's toys, and all over the walls. After it was determined that no other resource was available for the child, the mother agreed to sign a 3-day (3) consent to place the child into Foster Care.[101] Despite the mother's apparent continued drug use, failure to make any changes to her behavior after the removal of her other children, and the mother engaging in extremely violent and bloody behavior, the Office of the County Attorney refused to file a neglect petition and directed CPS to return the child to the home on December 9th, 2022, less than twenty-four (24) hours later because the mother agreed to clean the house and agreed to stay sober.

On December 10th, 2022, an on-call worker went to the mother's house after the child was returned and observed two (2) crack pipes with residue, scales, and other drug paraphernalia on the kitchen table. The mother denied possession of those items. At that time CPS executed an emergency removal. The following day the mother consented to the temporary removal of the child. On December 20th, 2022, Witness 11 closed the case and the allegations of inadequate guardianship, lack of supervision, and parental drug use were indicated.

The members of the grand jury find Witness 11's testimony to be credible and the testimony is supported by documentary evidence submitted to the grand jury which contains the case file for the matter of W. The members of the grand jury further find that given the facts and circumstances available to the Office of the County Attorney and their client's desire to remove the child their order to return the child based upon the empty promises of a safety plan was a reckless substitution of their judgment for that of their client, well outside the scope of any sound

[101] Id.

legal determination, and in direct contravention of the best interests of the child and their client, DSS.

Although the Commissioner of Social Services can exercise a temporary removal for seventy-two (72) hours, this authority was extinguished when the Office of the County Attorney exercised authority outside of the scope of their employment as attorney for the Department directing the return of the child. The credible evidence and testimony demonstrated that the legal authority granted by the law was superseded by the County Attorney's Office when they used their position as the legal authority for the county to direct that the child be returned, despite the Commissioner's temporary legal authority to do otherwise. Therefore, the credible evidence supports the finding that no child could be removed without the approval of the Office of the County Attorney.

Subsequent to this investigation, on or about February 26th, 2023, the mother gave birth to another child who was one-month (1) premature and the baby exhibited symptoms consistent with NAS. In addition, the Nurse reported that the mother was nodding off while holding the child. A neglect petition was filed by the Office of the County Attorney and the child was removed from the home and placed into Foster Care. The Office of the County Attorney described this case to Witness 11 as "a classic derivative". Witness 11 was surprised by the Office of the County Attorney's reaction because of their previous statements on other cases that "derivatives do not exist." There were no documented efforts made regarding reasonable efforts and none placed into the petition despite the Office of the County Attorney's standard requests for such efforts prior to the filing of such an action.

The members of the grand jury find the testimony of Witness 11 to be credible and the testimony is supported by documentary evidence.[102] The members of the grand jury further find that the evidence is demonstrative of the Office of the County Attorney's use of derivative neglect despite assertions of the theory's non-existence and begs the question as to why the Office of the County Attorney would direct the return of the mother's previous child under such dangerous circumstances. The case is a demonstration of the Office of the County Attorney's failure to exercise clear, competent, and consistent judgment as the legal advisor for DSS..

e. CPS Investigation of X[103]

On or about July 7th, 2022, the SCR received a report alleging in sum and substance that her child was born positive for methadone and cocaine. In addition, the mother admitted to using methadone, heroin, and marijuana.[104] CPS assigned caseworker, Witness 12. Witness 12 investigated the case and discovered that the child's withdrawal symptoms had worsened and the child was transferred to the NICU for NAS. In addition, the mother's toxicology came back positive for methadone, cocaine, and opiates. The mother reported to Witness 12 that she had used drugs four (4) or five (5) days prior to giving birth to the baby, and after she found out she was pregnant switched from sniffing heroin to using heroin intravenously. The mother expressed that she wished to sign the baby over to her mother to prevent the possibility of the baby going into Foster Care. Witness 12 entered into a safety plan with the mother requiring that the maternal grandmother watch the child and the mother continue to attend drug treatment, look for inpatient treatment, and obtain a mental health evaluation.[105]

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[102] Grand Jury Exhibit 46.
[103] Witness 12; Exhibit 34.
[104] Grand Jury Exhibit 34.
[105] Id.

On July 8th, 2022, Witness 6 contacted the Office of the County Attorney and informed them of the circumstances regarding the child's condition, the mother's heroin use, and the anticipation that CPS would request a petition for neglect. The Office of the County Attorney responded that they would get a petition ready to go and requested the pedigree information so that they could begin to prepare the petition.

On July 12th, 2022, Witness 12 attended a family review panel discussion and presented their concerns directly to the Office of the County Attorney, requesting a petition for neglect with a request to remove the baby. The Office of the County Attorney denied the request for a petition because the grandmother was going to file for custody. CPS requested the petition to force the mother to attend drug and alcohol treatment, parenting classes, and receive a mental health evaluation in an effort to improve the mother with the goal of creating a better parent, and ultimate re-unification with the baby. Witness 12 also expressed concerns to the Office of the County Attorney that the grandmother would get custody and the mother would be the primary caregiver because she lived in the same home because the grandmother worked.[106] When grandma worked the mother would be the most likely caregiver and would not have overcome her drug addiction.

On July 15th, 2022, the grandmother filed for custody of the baby. Prior to the baby's release from the hospital the ACS worker noticed that the grandmother had nothing to care for the baby upon their release. The ACS worker forced the grandmother to go and obtain items to care for the baby upon their release from the hospitals.

As part of the custody petition the Sullivan County Family Court Judge requested that CPS provide a report regarding their investigation so that the court could make a determination whether the grandmother was suitable for custody. Witness 12 prepared a three (3) page report and the

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[106] Id.

report was sent to the Office of the County Attorney. The report was returned by the Office of the County Attorney edited, reduced to one (1) page, and the office had removed any information stating the grandmother wished to take the baby home with no provisions to care for the baby and the mother failed to complete any intakes for several treatment programs.

After the grandmother received temporary custody of the child, she withdrew the petition for custody approximately one (1) month later. After receiving notification of the withdrawal and dismissal of the custody petition on August 22th, 2022, the Office of the County Attorney never filed the neglect petition initially requested by CPS. On August 5th, 2022, Witness 12 indicated the case against the mother as to the allegation of the parent's drug/alcohol misuse. The mother maintained custody of the child and was not required to comply with drug treatment.

The members of the grand jury find Witness 12's testimony to be credible and the testimony is supported by documentation provided to the grand jury[107]. The members of the grand jury find that the Office of the County Attorney did not make a legal determination and instead substituted their personal judgment for that of the wishes of their client, DSS. Furthermore, the Office of the County Attorney's determination placed the child at unnecessary risk and was against the best interest of the mother and the child. By preventing a court from ordering the mother to comply with drug treatment, mental health treatment, and parenting classes. Instead, the failure to file the petition allowed the mother to avoid any treatment for her addiction to heroin, make no improvements as a parent, and still maintain custody of the child. Compliance with said treatment could have provided the baby with a sober mother, a better more informed parent, and a parent who was not suffering from mental illness, all enormously beneficial to the child, a demonstrated priority of CPS, and a demonstrated inconvenience for the Office of the County Attorney.

[107] Grand Jury Exhibit 34.

3. Conduct Related to Sufficiency of Allegations: "Enough" to File a Petition

a. CPS Investigation of P[108]

This family has a long history with CPS and the criminal justice system. In 2017, CPS removed all five (5) children of the mother and her paramour predicated upon ongoing domestic violence in the presence of the three (3) youngest children. As a result, the paramour was arrested and criminally charged, prompting the issuance of a complete stay-away order of protection in favor of the mother and her three (3) youngest children. The order expires on July 22nd, 2032. Subsequently, all five (5) children were placed into the care and custody of their maternal grandmother in Orange County, New York. In 2022, the maternal grandmother died and the mother, her paramour, and the five (5) children moved back to Sullivan County. Although living in Sullivan County, the family was homeless, which necessitated them residing in condemned buildings and couch-surfing.

On January 9th, 2023, the SCR received a hotline report alleging that the mother had regained custody of the children, moved back to Sullivan County, and engaged in ongoing domestic violence between the mother and her paramour, as well as substance abuse. CPS assigned Witness 10 who commenced an investigation.

On January 11th, 2023, Witness 10 accompanied with members of law enforcement, conducted a home visit at paternal grandmother's residence where Witness 10 believed the family to be residing. Witness 10 made contact with the mother who informed the caseworker that she had not seen her paramour in months and further denied drug use. During this encounter, members of law enforcement located the paramour inside the residence in violation of the outstanding order

[108] Witness 10; Exhibit 36.

of protection, resulting in his arrest. The caseworker was further informed that the paramour consistently violated the order of protection since its issuance in 2017.

Witness 10 then asked the mother to take a drug test but she refused, admitting it would come back positive for narcotics. The mother, thereafter, agreed to a voluntary safety plan whereby the mother would cede contact with all five (5) children until engaging in mental health and substance abuse treatment, during which time the paternal grandmother would retain custody of the two (2) eldest children and a relative resource would obtain custody of the three (3) youngest children.

Shortly after, and during the vast majority of this investigation, the mother was incarcerated in the Sullivan County Jail on local criminal charges and, therefore, was unable to participate in these services.

Throughout the course of this investigation, it was reported that the mother, prior to her incarceration, had recently increased her drug usage, thereby seriously impairing her ability to care for the children. The children relayed to Witness 10 that the mother and paramour smoked crack-cocaine as one might smoke cigarettes. The two (2) eldest children reported that they confronted their mother about her addiction after finding the mother's crack pipes and witnessed ongoing domestic violence between the mother and her paramour.

On March 17th, 2023, CPS requested the Office of the County Attorney to file a removal petition. The Office of the County Attorney refused to file a removal petition The Office of the County Attorney, nonetheless, agreed to file a petition for services. In reliance on this assertion, the Witness 10 forwarded all of the documentary evidence related to this investigation to the Office of the County Attorney on March 21st, 2023.

On March 24th, 2023, Witness 10 emailed the Office of the County Attorney requesting an update on the status of the petition for services. They never responded. On March 27th, 2023, Witness 10 texted the Office of the County Attorney requesting an update on the status of the petition for services. They never responded. On April 19th, 2023, Witness 10 asked their supervisor to request the Office of the County Attorney provide an update on the petition for services.

Meanwhile, the relative resource having custody of the three (3) youngest children filed a petition seeking court-ordered guardianship of said children but refused to do the same for the two (2) eldest, who remained in the custody of paternal grandmother pursuant to the voluntary safety plan.

During the course of this investigation, the Office of the County Attorney failed to ever file a petition, despite DSS insistence that one (1) be filed to ensure the children could be placed pursuant to court order and his agreement to do so.

The members of the grand jury find Witness 10's testimony credible and further find that the Office of the County Attorney breached a duty to their client, DSS, for diligent representation. The Office of the County Attorney neglected a matter entrusted to them. As a result, the Office of the County Attorney unnecessarily placed the child at risk.

b. CPS Investigation of O.[109]

On July 19th, 2022, SCR received a hotline report alleging domestic violence between the mother and the father in the presence of their 2-week-old (2) child, as well as substance abuse by both parents. CPS assigned Witness 10 and they commenced an investigation.

[109] Witness 10, 16; Exhibit 35.

Pursuant to this investigation, the caseworker made contact with the mother who admitted in a sworn deposition that the father strangled her to the point of unconsciousness while the child was present in the same room. The mother had visible choke marks around her neck. As a result, the mother levied criminal domestic violence charges against father and secured a complete stay-away order of protection against the father protecting herself and the child. Based upon this information, the caseworker determined that the child has or is likely to experience physical or psychological harm due to the parent's domestic violence in the child's presence and, therefore, substantiated the allegations of inadequate guardianship.

Witness 10 subsequently learned that the parents recently relocated to New York just prior to the child's birth. The father has limited family connections to Sullivan County. The mother has no connections to Sullivan County other than that of the father.

The father has extensive criminal history, including prior felony and misdemeanor convictions for domestic violence and battery. The parents further appeared to have fled their previous state of Florida to evade an active arrest warrant for the father on battery and drug charges. The mother was not the first of the father's paramours to have accused him of domestic violence. This was also not the first instance of domestic violence to have occurred between the mother and father in New York. The mother admitted, and medical records confirmed, that in January 2023, while she was pregnant with child, the father violently strangled the mother to the point of unconsciousness requiring the mother to seek medical attention.

As a result of the July 19th incident, the mother agreed to a CPS safety plan requiring that she prohibit the father from contact with the child. The mother voluntarily moved into a domestic violence shelter and participated in multiple services as requested by the CPS as well as some that were not requested. Also, at CPS's request, the father voluntarily obtained a mental health

evaluation whereby he was diagnosed with Adjustment Disorder. The father, however, failed to engage in the recommended after-care treatment.

On July 28th, 2022, the mother inquired of Witness 10 about the circumstances in which the father would be permitted back in the home. Believing that allowing the father back in the home at that point in time would have imperiled the child's safety owing to the father's failure to engage in recommended treatment, coupled with his historical pattern of violent behavior, the caseworker responded that the safety plan will not be removed and, if she violates said plan, then CPS would file a neglect petition seeking removal of the child. Subsequent to this interaction, the mother's willingness to contact Witness 10 deteriorated.

On August 12th, 2022, the father appeared in the Sullivan County Court for sentencing on unrelated criminal charges when he was apprehended, pursuant to an arrest warrant issued to the New York State Police, and thereafter produced to the Town of Neversink Justice Court to be arraigned on criminal domestic violence charges stemming from the July 19th incident with the mother. The father was subsequently released on his own recognizance without the imposition of monetary bail.

That same day, CPS requested that the Office of the County Attorney file a neglect petition so that the parents could be court-ordered to attend services and cooperate with Witness 10. Witness 10 did not request removal at that time because the mother took appropriate steps to protect the child by entering the domestic violence shelter and participating in services. The Office of the County Attorney refused to file a neglect petition stating that the caseworker could not prove that the July 19th domestic violence occurred while the child was present in the same room. The caseworker disagreed with the Office of the County Attorney's conclusion as it was belied by the mother's own admission and the child's recent birth.

On September 29th, 2022, Witness 10 substantiated allegations of inadequate guardianship against the parents due to the ongoing domestic violence in the presence of the child.

On September 30th, 2022, SCR received a second hotline report alleging further domestic violence between the mother and the father. CPS again assigned Witness 10 to investigate.

Pursuant to this investigation, Witness 10 learned that the father traveled to the domestic violence shelter which housed the mother and child, conversed with the mother for a few hours about their relationship, observed messages on her phone which angered him, struck the mother in the eye causing severe injury, and then fled the shelter. The mother then contacted members of law enforcement who responded to the shelter and photographed the injuries. The mother, however, refused to pursue criminal charges.

On October 3rd, 2022, CPS requested the Office of the County Attorney file a removal petition since the mother failed to comply with services, wanted the father back into her life, and was dishonest with Witness 10. The Office of the County Attorney refused to file a removal petition stating that the caseworker could not prove that the mother had voluntarily permitted the father into the room and was willingly spending time with him. Witness 10 countered that CPS, nonetheless, would still be able to file a removal petition against the father since this shelter housed one family per room, the child was present in the room during the domestic violence, and the father was violating the order of protection. The Office of the County Attorney was unmoved and took no further action.

Fearing for the safety of the child and mother, Witness 10 requested the mother to relocate to a different domestic violence shelter since the father now knew their location. The mother refused. At this juncture, Witness 10 averred that, regardless of whether the mother willingly permitted the father into her room at the shelter the filing of a removal petition was warranted

given the mother's failure to comply with the safety plan, thereby imperiling the welfare of the child.

Thereafter, the mother's contact with the CPS waned. Caseworkers actively attempted to locate the mother at the mother's residence but were unable to find either the mother or the child. The father's family reported to the caseworker that the father, the mother, and the child were all back together.

Witness 10 secured sworn statements from the father's family that the father, mother, and child had been residing together in a camper, which lacked running water or electricity, on father's family property to avoid detection by law enforcement and CPS. The father's family requested the father, mother, and child relocate from their property when medication went missing.

On October 7th, 2022, CPS, again, requested the Office of the County Attorney file a removal petition. The Office of the County Attorney failed to respond to CPS's request until October 13th, when they refused to file a removal petition stating that the caseworker was unable to prove the violence was ongoing. The caseworker disagreed and retorted that the violence was clearly chronic and cyclical since there had been three (3) reports of domestic violence that year with the latest incident being seven (7) days prior; the mother permitted the father to violate the order of protection numerous times; the mother was in flagrant violation of the safety plan; and the family was overtly evading the CPS's detection.

Witness 10 continued to investigate and confirmed that, subsequently, the father, mother, and child had been residing at the Monticello Inn prior to management requesting their departure due to recent property damage within their room resulting from an apparent punch. The caseworker secured a statement from the innkeeper, the booking receipt, and photographs of the damage.

On October 19th, 2022, CPS, again, requested the Office of the County Attorney to file a removal petition. The Office of the County Attorney, now, agreed to file a removal petition. After drafting the removal petition the Office of the County Attorney hastily presented it to the caseworker for signature without affording them the opportunity to fully review it and filed it with the Family Court on October 21st, 2022. The caseworker was dismayed, however, after learning the full contents of the removal petition. The caseworker assumed the Office of the County Attorney would file a same-day emergency removal petition owing to the family's recent evasiveness from CPS as well as their demonstrated history of fleeing from authorities in other states. The Office of the County Attorney, however, filed a removal petition, on notice, which delayed the commencement of the removal proceedings to October 24th, 2022, thereby granting the parents several days to flee the jurisdiction.

The father's family contacted the caseworker on October 23rd, 2022, to advise that the father, mother, and child had packed their belongings and hailed a cab to Penn Station in New York City in an attempt to leave the state. Witness 10 notified the New York State Police about the family's intention to flee the court's jurisdiction but was advised that, without a court order preventing the family from leaving, New York the State Police were powerless to intervene.

On October 24th, 2022, the father, mother, and child all failed to appear in court for the removal proceeding. Acknowledging the same, the Office of the County Attorney thereafter withdrew the petition, with the CPS's consent, claiming that if the court ordered removal of the child to the care and custody of the Department it would have no way of locating the child.

On November, 21st, 2022, the Office of the County Attorney advised the caseworker to indicate the case but then close it because the family was no longer in the State of New York.

On June 1st, 2023, North Carolina CPS contacted Witness 10 requesting their records relative to this family. North Carolina CPS further advised that it had successfully removed the child from the custody of the mother and father for domestic violence and substance abuse.

The members of the grand jury credit Witness 10's testimony and agree that the outcome in this case should have been different if the Office of the County Attorney had agreed to file a petition for services in August because Witness 10 would have had more access and would have been able to request a removal earlier in October when the mother was no longer staying in the domestic violence shelter and the safety plan had consistently been violated. The members of the grand jury further finds that the Office of the County Attorney's actions recklessly permitted the placement of a child in a situation exposing the child to the potential for domestic violence for an additional seven (7) months without legal justification and again the Office of the County Attorney substituted their poor *personal* judgment for their client, DSS.

c. CPS Investigation of U.[110]

On November 17th, 2022, SCR received a hotline alleging, in sum and substance, that the mother was under the influence of an unknown drug, had been acting erratically all week, and had previously overdosed on Adderall. On November 29th, 2022, SCR received another hotline report alleging that some of the children were scared for their own safety because of the mother's continued erratic behavior, including rubbing oils on the children while they were attempting to sleep to cure them of demonic possession. Previous hotline reports alleged that the mother's mental health was continuing to deteriorate, and also alleged that the father was abusing drugs. Subsequent reports detailed the father's increasingly severe physical punishments of one of the youngest children. CPS assigned a caseworker, Witness 11, and they continued to investigate the case.

[110] See Grand Jury Testimony of Witness 11, 16, 2, 3; Exhibit 47.

The mother was taken to the hospital and assessed to have been experiencing mania with psychosis and was discharged with a diagnosis of substance induced psychotic disorder. On December 1st, 2022, the mother was again admitted to the hospital during another psychotic episode and the hospital determined that she was not sane enough to sign her own medical consents. The mother admitted to abusing her Adderall prescription. The father reported that the medical professionals expected this sort of manic episode to occur for a while. The children had previously been removed for an extended period of time due to the parent's drug usage. The older children wanted to be removed, one of the children was not registered for school, all of the children were performing below grade level, and one could not even read.

The case continued and in January 2023, a new report was received containing allegations that the children did not have enough to eat and that the father had beaten one of the younger children including contact with a belt and punches in the child's head, and had threatened that same child with a beating if they ate a yogurt when hungry. The father had punished that same child on the morning of January 23rd for eating multiple Uncrustables by covering one (1) in dirt by wiping the Uncrustable on the floor and forcing the child to eat it. The father had also punished that same child by forcing them to sit in a particular position until his arms and legs lost feeling. The mother was also medicating the children with unprescribed medications.

The parents were constantly arguing about pills in the bathroom and one of the children was able to identify when the parents were or were not high. The father becomes drowsy and violent. The mother becomes obstinate, picks her face, and walks around the house half naked. The two have been seen by the children performing sexual acts and the mother has sexual conversations with the father while touching his penis.

On January 20th, 2023, a report from the Sullivan County Sheriff's Department revealed that the mother was under the influence while home with the children and was putting her fingers in and out of her anus and vagina. One (1) of the children observed this behavior.

On January 24th, 2023, CPS effectuated an emergency removal of the children under the Commissioner's authority and authorization. The Office of the County Attorney, at that point, was required to file a removal petition in Family Court within seventy-two (72) hours.

On the morning of January 27th, 2023, the Office of the County Attorney sent a full-page email detailing their view of the facts and evidence, and that we can file against mom but my suggestion would be a very detailed safety plan[.] . . . Thank you for your amazing cooperation and assistance with this matter, the children must be returned today and the safety plan entered into today if that can be achieved."

The casenote from the same day, states that a caseworker "HAD PARENTS SIGN SAFETY PLAN AND THE CHILDREN WILL BE RETURNED HOME TODAY. DIRECTOR . . ., COMMISSIONER . . ., AND THE CPS DEPARTMENT DO NOT AGREE THAT CHILDREN [sic] SHOULD BE RETURNED HOME."

We find that the testimony provided by Witness 11 was credible and supported by documentary evidence submitted to the grand jury.[111] The members of the grand jury further find that the conduct alleged represents a seriously imminent risk to the childrens' safety. The combination of the father's corporal punishment, the parents sexual demonstrations in front of the children, apparent attempts to remove demons from the children, and the mother's clear instability clearly would provide any rational person to find that those children needed to be removed from the home to protect their safety, and the Office of the County Attorney's direction to return those

[111] Grand Jury Exhibit 47.

children back to the home and re-enter them into a home filled with such instability demonstrates a gross abuse of discretion.

d. CPS Investigation of N.M.

On February 7, 2022, a hotline report was received. Caseworker 5 was assigned and commenced an investigation. Subsequent hotline reports by services providers were received for excessive corporal punishment, withholding of food, inappropriate sleeping arrangements, and medical neglect.

The children had previously been removed from their mother in a different county. They then went to live with a different relative in another county but were, unfortunately, sexually abused in that home, which required their removal from that household. The children then moved in with their father, his paramour, and his paramour's children in Sullivan County. At the father's house the subject children were provided with a single bedroom to share.

The father treated the subject children and his paramour's children drastically differently. The father forced the subject children to sleep on crib mattresses as a form of punishment for their bed wetting. When the father, his paramour, and his paramour's children went to the movies, Legoland, or for pizza, the subject children were made to sit, alone, facing cameras, unpermitted to speak or play with toys, in a house that could only be unlocked by the father's cellphone applications. At home, the subject children were forced to eat food they did not like as an additional form of punishment. At school, the father only permitted the children to drink an 8 ounce bottle of water, which contained mold.

The children both independently reported this treatment, which the father admitted as well. The father even asked a service provider if there was a product he could purchase that would electrically shock the children when they urinate at night.

The father had misrepresented the subject children's medical history to a nurse practitioner in order to get a false letter stating that the subject children's food and water intake should be limited at school due to suspected diabetes and persistent bed wetting. Neither child was diabetic, however, and would have been sent to a psychologist if the nurse practitioner had been made aware of their actual medical history—a history of sexual abuse. The nurse practitioner had referred the children to a urologist for the bed wetting and, once made aware of the children's full history, did refer them to a psychologist. However, the subject children were never taken to either the urologist or the psychologist.

The caseworker was afraid to visit the home due to the father's volatile behavior. The father had previously locked a service provider in the home, and had made statements that all social workers should be shot. One child slept on a crib mattress in the living room and the other child slept on one crib mattress.

The Department asked the County Attorney's Office for a petition for court ordered medical services, so that the father would have to take the subject children to the urologist for the bed wetting to eliminate caseworker concerns that either urinary tract infections or active sexual molestation could have been the cause. The County Attorney's Office refused, explaining that the father's failure to take the subject children to a urologist did not rise to the level of medical neglect even though the bed wetting formed the basis for the father's withholding of food and water. The County Attorney's Office further explained that the father leaving the subject children home alone was more of a criminal act than child neglect because they had been given a phone; and suggested the caseworker connect with law enforcement about a potential criminal charge.

The caseworker did follow up with a member of law enforcement who reported that the subject children would need to be found home alone for charges to be filed. Knowing the subject

children had been told to hide, the caseworker did not think they would be able to find the subject children home alone.

Lacking a petition, the caseworker indicated the report on the father for inadequate guardianship and closed the case. The caseworker still fears for the safety of these children.

We find the witnesses testimony credible as to the situation these girls faced. We find that the caseworkers limited request for an order for medical services was abundantly reasonable, legally justified, and find that even a request for removal would have been justified. The Office's disregard for these two children and their unacceptable living situation demonstrates that they are manifestly unfit to hold responsibility for the lives of any children in Sullivan County.

4. Article 6 Custody Instead of an Article 10 Neglect Petition

Article 6 of the New York Family Court Act governs petitions for those seeking to allocate care and custody of a child privately and based on the best interests of the child. Examples of those individuals likely to file a custody petition under Article 6 are parents, grandparents, and aunts or uncles. Article 10 of the New York Family Court Act governs the neglect petitions discussed thus far in the report and seeks to ensure that children can be safely reunited with their parents after a temporary disruption in custody occasioned by neglectful conduct.[112]

To be clear, said petitions are filed by private individuals and /or agencies and not by the local government with oversight over the custody arrangement or timing and advisability of a return to the child's original guardian or parent. The Office of the County Attorney declines to file CPS's requested petition if an Article 6 petition is or will be filed. These acts contravene their duties and obligations to safeguard the children of Sullivan County and have, in turn, directly imperiled their safety by waiting for the relative to file a petition and ignores the possibility that

[112] Id.

the relative will withdraw the petition after the closure of the case, thereby returning custody to the subject of the CPS investigation.

a. CPS Investigation of A.[113]

On or about March 18, 2023, the biological father forcibly raped biological mother at knifepoint while in the presence of their seven (7) month old child, who was sleeping in a crib next to the bed where the assault occurred. The biological father was arrested and jailed shortly thereafter.

On or about March 27, 2023, a hotline report was received with allegations that the father had sexually assaulted the mother at knifepoint in the presence of the seven (7) month old child. After the father was jailed the child remained with the mother. Caseworker, Witness 4, was assigned and commenced an investigation.

Witness 4 obtained the child's medical records on or about March 30, 2023. The child was born on July 29, 2022. By August 30, 2022, a medical checkup revealed that the infant was down to the 25th percentile for weight having gained only 5 ounces during the infant's first month of life. By September 15, 2022, a checkup of the child revealed that the infant had only gained another 3.5 ounces dropping him to the 5th percentile for weight. At that appointment the infant was referred to a pediatric gastroenterologist.

The September 28, 2022, checkup showed that the child had gained 1 pound 6.5 ounces in the previous two weeks, bringing the child up to the 9th percentile in weight; however, the mother was encouraged to attend the gastroenterology and neurology appointments for the child. The child was not taken to the pediatrician on September 28, 2022, or March 6, 2023, as directed; during that six (6) month period the child gained a mere 2 pounds 14 ounces placing him below the 3rd

[113] Witness 4; Exhibit 11.

percentile for weight. Yet, the next week, per medical records, the child gained 8 ounces of weight, and in the subsequent 2 weeks gained 1 pound 8 ounces. As such, the child gained 2 pounds in three weeks, only 14 ounces less than he had gained in the previous six (6) months.

The child was therefore diagnosed with failure to thrive, carrying risk of impaired growth development, cognitive development, and even death. The mother had failed to take the child to any appointment for either of the two (2) specialists to which he had been referred and the pediatrician expressed his concerns for the child to Witness 4.

Very early in Witness 4's investigation into this case, the mother moved with the child from Sullivan County to Schenectady County to live with the mother's new paramour. Mother and her new paramour met on Tinder just over one (1) month prior to commencing their cohabitation. Witness 4 had trouble getting a hold of the mother to discuss the pending investigation.

On April 6, 2023, Witness 4 traveled to the mother's new paramour's residence to check on the child. Case Worker arrived at 10:45am to the mother claiming the child had slept through the night and was still sleeping; however Witness 4 found the child soaked in urine from his knees to his chest lying in a pack-n-play covered with a blanket. At that point, Witness 4 had the mother agree to a safety plan where the maternal grandfather would take care of the child. However, the grandfather was unable to be a long-term caregiver. The child's medical condition improved significantly once he began living with the grandfather.

On April 13, 2023, the Office of the County Attorney agreed to file a neglect petition seeking removal. Witness 4 expected the petition to be filed with expediency given the child's and grandfather's medical concerns. However, by April 18, 2023, the mother had broken up with her paramour, moved in with the grandfather and the child in Sullivan County, and the mother and grandfather asked Witness 4 about the potential for joint legal custody of the child. Witness 4

found this an acceptable situation in the interim if the Grandfather had joint legal custody and residential custody, but Witness 4 wanted a neglect petition filed so that the Department could remain involved with the family given the medical risk to the child.

On April 21st the Witness 4 and grandfather agreed that he would seek joint legal custody of the child. The grandfather was aware of the need to reach out to Witness 4 if the mother was not properly caring for the child, and had been reaching out. As a result of this and the lack of response from the County Attorney's Office, Witness 4 agreed to hold off on the petition if the grandfather obtained joint custody – though the Case Worker did still want a petition. In Witness 4's previous employment Witness 4 would have had a petition filed expeditiously.

On May 5th the mother filed a custody petition and was granted full custody of the child. The grandfather never filed any custody petition but did contact Witness 4 on May 22nd stating that the mother and child would continue to live with him until the mother "gets everything worked out."

Investigations need to be closed within sixty (60) days where no petition is filed by the Department. In this investigation, no petition was filed and so the case needed to be closed even though the grandfather had not filed a custody petition. The safety plan terminated when the case was closed. Witness 4 has not heard from the grandfather since the investigation closed. The mother currently has full custody of the child and can legally take him any time, anywhere, to live with anyone. There is nothing protecting this child at this time.

We find that the testimony provided by Witness 4 was credible and supported by documentary evidence submitted to the grand jury.[114] The members of the grand jury further find that the conduct alleged represents quite clearly an imminent risk to the child's safety. The

[114] Grand Jury Exhibit 11.

combination of the mother's disregard for the child's precarious medical condition and the need to provide the child with consistent and/or sufficient nourishment would provide any rational person to find that the child should have been removed to ensure the child's continued survival and ensure some accountability until the child could be safely returned to the mother's sole custody.

b. CPS Investigation of C.[115]

On March 27th, 2023, the SCR received a report alleging that the mother had left a hickey bruise on the child's cheek. Photographic evidence of the hickey on the child's cheek was submitted into evidence.[116] CPS assigned Witness 4 to investigate the case. Witness 4's investigation revealed that the child was living with their mother and maternal grandfather. Witness 4 instituted a safety plan requiring that the mother not be left alone with the child. Witness 4 had reservations regarding the efficacy of this plan. CPS requested that the child be removed to the custody to the maternal grandmother who did not reside with the mother or the grandfather. The Office of the County Attorney denied CPS's request for a petition and advised them to wait until the maternal grandmother filed for custody of the child pursuant to Article 6 of the Family Court Act.

While waiting for the maternal grandmother to do so, without court intervention and the mere issuance of a safety plan, the mother, without the benefit of CPS supervision, bit the child approximately six (6) times. Photographic evidence depicting the bite marks were submitted into evidence before the grand jury and portray bite marks to the child's shoulder, tricep, forearm, and a bruise to the child's cheek.[117]

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[115] See Grand Jury Testimony of Witness 4; Exhibit 12, 13.
[116] Grand Jury Exhibit 13 containing three photographs.
[117] Grand Jury Exhibit 12 containing five photographs.

Subsequent to learning this, CPS went to the child's mother and requested that she relinquish temporary custody to the maternal grandmother. Witness 4 further testified that in their experience in working in a separate county with a different legal department the legal department would have moved forward with a neglect petition after the initial incident.

The grand jury finds witness 4's testimony to be credible and agrees with Witness 4's assessment that the Office of the County Attorney's failure to file a petition for removal after the first incident was inappropriate given the imminent risks associated with leaving the child in the home with the mother who had committed the initial act of abuse. That assessment to remove the child was bolstered by the additional act of abuse perpetrated on the child while the child waited for the maternal grandmother to file a petition for custody pursuant to Article 6.

C. Conduct in Relation to Fair Hearings

1. CPS Investigation of J.[118]

On June 20, 2021, CPS received a hotline report with allegations that the mother had overdosed at home as the sole caregiver for her four (4)-year-old child and was only discovered when the grandmother saw the child crying on the mother's security system saying that he could not wake the mother up. A caseworker was assigned and an investigation commenced.[119]

In addition to the facts of the hotline report, the caseworker learned that the mother had needed three (3) doses of Narcan to be revived from the state in which she was discovered: unresponsive, blue, and without a heartbeat. The mother had started using heroin at age sixteen (16) and admitted to having overdosed on heroin that day. The report was indicated and a neglect petition was filed. The mother tested positive for fentanyl after the petition was filed.

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[118] Witness 6. Exhibit 26.
[119] See Grand Jury Testimony of Witness 6; Grand Jury Exhibit 1;Grand Jury Exhibit 26.

The mother appealed the indicated report through the Fair Hearing process. The indicated report was affirmed during the administrative review and the process moved forward to a hearing in front of an administrative law judge from OCFS. The caseworker did want the indicated report to have been affirmed at this hearing because of the mother's extensive history of drug use.

The Office of the County Attorney, intentionally presented no evidence in support of the indicated report at the Fair Hearing held on March 21, 2023, thereby agreeing to have the indicated report changed to an unfounded report and sealed.

The members of the grand jury credits the testimony of the caseworker and agrees that the Office of the County Attorney should have presented evidence at the fair hearing to defend CPS's determination. We further find that the Office of the County Attorney breached their ethical duty to abide by the specific allocation of authority between client and a lawyer by failing to consult CPS as to whether they wanted the indicated report defended at the fair hearing. This action has damaged CPS because they can no longer use the report against the mother in further proceedings to protect the child.

2. CPS Investigation of Unnamed Doctor[120]

CPS received a hotline report and investigated to learn that the drunken father had attempted to rape the mother in the presence of their fourteen (14)-year-old child who then grabbed a knife in an attempt to protect the mother.[121] The father was a doctor and an alcoholic, and that the child was extremely upset by the incident. The report was indicated.

The father appealed the indicated report through the Fair Hearing process. The caseworker would have wanted the indicated report to have been affirmed at this hearing. The Office of the

[120] See Grand Jury Testimony of Witness 6.
[121] Id.

County Attorney presented no evidence in support of the indicated report at the Fair Hearing, thereby agreeing to have the indicated report changed to an unfounded report and sealed.

The caseworker believed that work should have been done to have the indicated report affirmed due to the severity of the conduct and the father's profession.

The members of the grand jury credits the testimony of the caseworker and agree that the Office of the County Attorney should have presented evidence at the fair hearing to defend CPS's determination and work should have been done to have the father's indicated report affirmed at the Fair Hearing. We further find that the Office of the County Attorney breached their ethical duty to abide by the specific allocation of authority between client and a lawyer by failing to consult CPS as to whether they wanted the indicated report defended at the Fair Hearing level. This action has damaged CPS because they can no longer use the report against the father in further proceedings to protect the child.

3. CPS Investigation of H.[122]

In June and July of 2019, several hotline reports were received regarding the same child. A caseworker was assigned and an investigation commenced.[123]

The first report was that the child had sustained an injury with unknown causes while spending time with the father, the report had only been called in because a nurse had heard the mother coaching the child to say the father caused the injury. The child had injured their arm during a fall at school on the playground. Then on the same day the child fell on the same arm after-school at the father's house. The child was taken to the orthopedist for a suspected wrist fracture and received a brace for the arm. The mother had repeatedly permitted the child to remove the brace, telling the child it was not necessary. The orthopedist called CPS to disagree and medical records

[122] See Grand Jury Testimony of Witness 6 and Witness 12. Exhibit 25.
[123] See Grand Jury Testimony of Witness 1; Witness 6; Witness 12; Exhibit 1; Exhibit 25.

indicated that the brace was to remain on until the follow-up appointment. The orthopedist was concerned that the child was not wearing the brace continuously. Subsequent orders from the orthopedist were for occupational therapy and continued brace wearing.

The mother later stated of the injury in a discussion about the child's brace wearing habits, "I'm a nurse I know I checked and nothing was wrong." The mother had obtained a note from the child's ancillary doctor stating that the child was cleared for gym and did not need to wear the brace—the mother had not been informed that there was a recommendation to see an orthopedist. While the mother appears to have been a nurse of some form; she was not a Registered Nurse, and she was not an orthopedic physician.

The caseworker indicated the report against the mother for her actions in coaching the child to say that the father or the father's paramour had hurt the child and for a domestic dispute with the child's aunt in front of the child. The case was then closed.

The mother appealed the indicated report through the Fair Hearing process. The indicated report was affirmed during the administrative review and the process moved forward to a hearing in front of an administrative law judge from OCFS. The caseworker would have wanted the indicated report to have been affirmed at this hearing. The Office of the County Attorney, through their staff, presented no evidence in support of the indicated report at the Fair Hearing, thereby agreeing to have the indicated report changed to an unfounded report and sealed.

The caseworker believed that work should have been done to have the indicated report affirmed due to the severity of the conduct and the mother's profession.

The members of the grand jury credits the testimony of the caseworker and agree that the Office of the County Attorney's office should have presented evidence at the fair hearing to defend CPS's determination work should have been done to have the mother's indicated report affirmed

at the Fair Hearing. We further find that the Office of the County Attorney breached their ethical duty to abide by the specific allocation of authority between client and a lawyer by failing to consult CPS was not consulted as to whether they wanted the indicated report defended at the Fair Hearing level.This action has damaged CPS because they can no longer use the report against the mother in further proceedings to protect the child.

4. CPS Investigation of S[124]

On November 15 2020, CPS received a hotline report alleging that a nineteen (19) month old child had sustained multiple bruises to the leg, arm, check, forehead, both ears, and the back of the head, as well as a significant bump on the forehead with swelling on the left side of the face and ear while in the care of the mother and the father who had no plausible explanation for the injuries. A caseworker was assigned and an investigation commenced.[125]

The child had suffered a skull fracture to the parietal and occipital bones. Approximately half of the child's head was bruised where the skull was fractured. The mother initially stated to hospital personnel that she had never taken her eyes off the child or that the child had only been out of her sight for three hours when the child spent time with the father. Later the mother reported to hospital personnel that the child must have sustained the injuries by rolling in the crib and hitting their head, the mother having heard no pain cries over the previous few days. Later, the mother's story changed again; the child and an older sibling were playing in a different room while the mother and her paramour were in bed, heard a loud bang followed by crying on the baby monitor, left their bed, and found the child standing in the door to that other room crying.

[124] See Grand Jury Testimony of Witness 2, 10. Exhibit 39, 1.
[125] See Grand Jury Testimony of Witness 10; Witness 2; Exhibit 1; Exhibit 39 [case record, medical records, photographs].

The father reported that the mother had dropped the child off the previous day, Saturday, and within three (3) hours, upon noticing multiple bruises, he called the mother to take the child to the hospital. The mother's paramour had been with the mother and child for the past three (3) days and the mother initially lied by saying that she had not left him alone with the child. The child's older sibling did not know how the child had been injured but stated that it had happened at the mother's home when the paramour was present in the sibling's bedroom. The daycare provider said that the child had a black eye the previous Monday and, although expecting the child on Thursday had received a text from the mother reporting the child would be with the father that day.

The consulted medical expert opined that, as a single impact fracture, the expert was more concerned for inadequate guardianship than abuse. Falling was a plausible explanation for the skull fracture. However, the mother's account varied as she spoke with the hospital, pediatrician, law enforcement, and CPS, and those explanations were inconsistent and incomplete. The report was indicated as to the mother and unfounded as to the father, and the case was closed.

The mother appealed the indicated report through the Fair Hearing process. The indicated report was affirmed during the administrative review and the process moved forward to a hearing in front of an administrative law judge from OCFS. The Office of the County Attorney, through their staff, presented no evidence in support of the indicated report at the Fair Hearing held on October 26, 2021, thereby agreeing to have the indicated report changed to an unfounded report and sealed.

The next CPS involvement with the mother, the paramour, and the child was when that same child died on January 25, 2022. A hotline report was received that day including allegations that the child had been found unresponsive and not breathing while in the care of the mother and

her paramour. The medical professionals found the mother's timeline questionable as the child had been inappropriately cold when EMS arrived.

The medical evaluations and autopsy revealed bruising to the child's torso, extremities, face, scalp and spine, ruptured small and large intestines, lacerations to the intestinal tract, and abdominal hemorrhaging. The child had bled out internally, she had been beaten horribly. As a result of the accompanying criminal investigation, the mother and her paramour were charged, convicted, and sentenced to incarceration for their respective roles in the child's death.

Caseworker 10 was assigned and conducted an investigation. The mother again did not know how the child had been injured, even though the injuries this time were life-ending and violent. The now-deceased child had over the course of the previous three (3) months arrived at daycare with concerning bruises all over their body including a black eye and stomach bruise.

The caseworker, after reviewing the mother's history with the Department as part of the investigation, thought work should have been done to have the indicated report affirmed because there had been plenty of evidence and the mother's employment was with developmentally disabled/special needs populations for which society expects extra attention and supervision. The caseworker does not believe that CPS was consulted because they and their colleagues were upset when they all learned the indicated report had been permitted to be overturned.

The members of the grand jury credits the testimony of the caseworker and agree that the Office of the County Attorney should have presented evidence at the fair hearing to defend CPS's determination and work should have been done to have the mother's indicated report affirmed at the Fair Hearing. We further find that the Office of the County Attorney breached its ethical duty to abide by the specific allocation of authority between client and a lawyer by failing to consult CPS as to whether they wanted the indicated report defended at the Fair Hearing. The case

demonstrates a consistent and pervasive pattern of extremely poor judgment on behalf of the Office of the County Attorney.[126]

5. The Office of the County Attorney's Fair Hearings

The members of the grand jury find the data provided by OCFS the year of 2022 shows that of sixteen (16) hearings completed, the County Attorney's Office presented no evidence at nine (9) of these hearings. In 2023, of the eight (8) hearings completed, the County Attorney's Office presented no evidence at five (5) hearings.

Based upon the exhibits provided to the grand jury the Office of the County Attorney's approach to CPS can be defined as anything but aggressive as the numbers of petitions have decreased, the numbers of removals have decreased, and their office has presented no evidence at Fair Hearings over 50% of the time year over year to date.

[126] Grand Jury Exhibit 2.

IV. OTHER CONDUCT UNBECOMING OF THE OFFICE OF THE COUNTY ATTORNEY

A. Treatment of CPS and their employees[127]

The credible testimony before the grand jury supports the findings that the Office of the County Attorney does not permit CPS employees to sit at the table in court with them while in court. It is not a customary practice within the legal profession to inform your client that you should not attend a court proceeding and if you are to attend that you will not sit at the table with your client. Caseworkers are unable to effectively communicate with the Office of the County Attorney in court regarding their positions and to provide them with necessary case information in the courtroom when they are not seated next to them. The Office of the County Attorney is not providing effective representation to the client by failing to have the client seated at the table and further alienates and perpetuates an oppositional relationship as opposed to a collective relationship necessary to be fostered with one's client.

B. The Coroner's Problem[128]

Witness 7 testified that they were present at a family review meeting where the County Attorney's Office was present and a female supervisor presented a case that Witness 7 had covered while a caseworker was on vacation. The female supervisor informed the Office of the County Attorney that the children had reported that they saw the mom and dad using drugs and were under the influence, there was also domestic violence in the home and the children hid in the closet when the police showed up. The female supervisor further informed the Office of the County Attorney that the father had overdosed and died and CPS was seeking a removal. The Office of the County Attorney ignored the supervisor and Witness 7 reiterated the request to them, at which point the

[127] Witness 3, 4, 5, 6, 8, 10, 11, 12, 13 and 17.
[128] Witness 7.

Office of the County Attorney stated in reference to the request, "That seems like the coroner's problem now," and did not grant the request for removal. The members of the grand jury find Witness 7's testimony to be credible and further revealing of the Office of the County Attorney's unfit and callous outlook towards their responsibilities as representative of the interest of DSS and CPS.

C. Allegations of Disparate and Condescending Treatment of Employees[129]

The members credit the testimony of Witness 7 alleging that the Office of the County Attorney treats the women caseworkers and employees differently than the male caseworkers. Examples include testimony by Witness 13 that they take a tone and demeanor of talking down to Witness 13. Witness 7 testified that they needed to reiterate a position because the position of a female caseworker was being ignored by the Office of the County Attorney, however, when reinstated by Witness 7, the position was acknowledged. Witness 15 testified that the Office of the County Attorney is often dismissive of female positions or concerns. Witnesses 3, 13, and 15 testified that the Office of the County Attorney has asked whether the witnesses had letters after their names, insinuating they have less education while knowing that their position requires a bachelor's degree. In addition, Witnesses 6, 11, and 13 testified that they are made to feel incompetent when spoken to by the Office of the County Attorney. Witness 15 described the Office of the County Attorney as having no respect for women and behaving in a degrading manner. The members of the grand jury find this testimony to be credible and unbecoming.

[129] Witness 3, 6, 7, 11, 13 and 15.

D. Fiduciary Responsibility to the Client[130]

The members of the grand jury credit the testimony of Witness 19 and the supporting documentary evidence filed[131] demonstrating that the Office of the County Attorney was put on direct notice of orders prepared by the County Attorney's Office that did not meet federal audit standards. Moreover, the credible testimony demonstrated that the Office of the County Attorney has failed to take any steps whatsoever to make changes to those orders to prevent the loss of federal funding. Further, the members of the grand jury find that as a result of the Office of the County Attorney's conduct, Sullivan County has the potential to lose $434,000.00. This represents a reckless disregard for County assets and is completely incongruent with the fiduciary duty that the Office of the County Attorney holds to limit the legally imposed financial liabilities upon the county.

E. Failure to Represent DSS position

1. Matter of W.[132]

The mother's child was placed into care and Witness 13 was assigned to the mother's case. After the child was placed into care the mother received supervised visitation. At the supervised visitation the mother consistently nodded out while holding her child. Nodding out is a condition consistent with drug use that causes the person to fall asleep. However, those familiar with drug abuse can identify the difference between someone nodding out and someone merely falling asleep. In this particular instance at one supervised visit a Sheriff's deputy notified Witness 13 to come to the area where the visitation was taking place. Upon coming to the area, Witness 13 looked through the glass and observed the mother open and her eyes barely open sitting in a chair

[130] Witness 19. Exhibit 74.
[131] Grand Jury Exhibit 4 and Grand Jury Testimony of Witness 19.
[132] Grand Jury Testimony of Witness 13, 8 and 3. Exhibit 40, 43.

with the child running around the room. The Sheriff informed Witness 13 that he had Narcan if Witness 13 needed to use it. The mother would attend nearly every visit with the child in that condition. At times during other supervised visitations the mother was seen slumped over and drooling. At other times the mother was seen nodding off while holding her infant child in her arms. Witness 13 requested that visitation be suspended because the mother's condition was endangering the infant. Witness 13 sent the Office of the County Attorney photos and video of the mother nodding out with the child in her arms. The Office of the County Attorney stated that the visitation could not be suspended, but ended early. Witness 13 put together two letters addressed to the Judge outlining concerns with the mother and requesting suspension of visitation until the mother became compliant with treatment and the letter was forwarded to the Office of the County Attorney to provide to the court. The Office of the County Attorney disagreed with DSS request and stated in an email, "[a] sleeping mother is not dangerous for the children and so we would need to wake her and continue the visit unless she says that she wants to continue the visit."[133]While in court, the Office of the County Attorney did not provide the letter to the court and instead represented to the court that the client, DSS wished to suspend visitation but they did not agree with their request. Two days later, the Office of the County Attorney made the independent personal determination that someone nodding out with an infant in their arms could be in danger of harm.

After coming to that determination the Office of the County Attorney requested that Witness 13 create another letter for the court and the mother's visitation was suspended at the time of the disposition of the case.

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[133] Grand Jury Exhibit 43.

The members of the grand jury credit the testimony of Witness 13 and further find that the Office of the County Attorney has placed their own personal beliefs and positions at odds with the position of their client in violation of their duty to advocate for their clients objectives. Instead of advocating for their client's position, the Office of the County Attorney substituted their own personal belief that suspending the visitation for the mother was punitive[134], not a legal determination, and then two days later, when the Office of the County Attorney determined that such conduct was dangerous to the child and they made the decision to make an application consistent with their client's wishes and objectives. The grand jury finds that the Office of the County Attorney lacks the judgment required to protect the children of Sullivan County in their failure to see an obvious danger of dropping an infant if held in a mother's arms while nodding out. Again, the Office of the County Attorney has demonstrated a consistent lack of urgency or awareness when addressing dangerous circumstances children are confronting in this county.

F. Culture Within CPS[135]

The members of the grand jury find that the testimony presented represents that the Office of the County Attorney has created a culture within CPS where caseworkers do not feel that they can adequately protect the children of Sullivan County. Moreover, multiple witnesses stated that they did not believe that the Office of the County Attorney's representation of CPS was keeping children safe. The members of the grand jury further find that the Office of the County Attorney has contributed to the loss of staff, one witness testified to as many as twelve (12) employees within DSS leaving due to relations with the County Attorney's Office, specific to the Office of the County Attorney, fostering an environment of opposition incongruent with the customary

[134] Grand Jury Exhibit 40.
[135] Witness 3, 6, 7. Exhibit 88.

attorney client[136] relationship through comments directed at staff, failure to permit caseworkers to sit at the table in court, failure to request the consent of the client or conference the matter with caseworkers prior to settling cases, failure to consult the Department regarding their positions on matters involving Fair Hearings, dismissing their concerns as squarely within the purview of the attorney when requesting to be consulted regarding Fair Hearing decisions[137], presiding over a large reduction in the filing of petitions and removals while the number of hotline calls have remained relatively constant[138], failing to provide the Department with court orders in a timely manner, presenting evidentiary obstacles for the filing of petitions not customary within the profession, and taking positions in opposition to or not previously agreed upon by CPS.

The extent and pervasiveness of the institution of this culture of powerlessness and a complete inability to do their jobs[139] was further demonstrated by the credible testimony from Witness 3 who found that caseworkers were unfounding cases because the Office of the County Attorney would not move forward with legal action requested on a case. This forced Witness 3 to instruct CPS caseworkers that cases were to be indicated or unfounded pursuant to their independent judgment and *not* the County Attorney's decision not to pursue legal action on a case.

[136] Grand Jury Testimony of Witness 7.
[137] See Grand Jury Testimony of 18.
[138] Grand Jury Exhibit 88.
[139] Grand Jury Testimony Witness 6.

V. CONDUCT OF COUNTY ATTORNEY'S OFFICE INVESTIGATION OF A.L. & C.L.[140]

A. CPS Investigations of A.L. & C.L.

On December 26th, 2021, Sullivan County received a report from the State Central Register ("SCR"). The report came from medical staff at Garnet Health-Harris Campus and stated that the mother tested positive for cocaine and methadone, the mother and father were impaired at the time of their arrival at the hospital, and their newborn baby was born at home and then subsequently brought into the hospital. Further, the mother had only attended one (1) prenatal visit with the baby during the pregnancy and the baby was born pre-maturely at thirty-seven (37) weeks old.

Case Worker, Witness 6, working on call at the time the report came in, spoke with the source of the report who informed Witness 6 that the baby was jittery and could not regulate their body temperature. The source of the report further confirmed with Witness 6 that the mother appeared to be under the influence of drugs when arriving at the hospital.

CPS investigation revealed that the mother of the child had previous indicated reports investigated by the Administration for Children's Services ("ACS"), stemming from a hotline report received on November 12th, 2017, alleging inadequate guardianship of the mother's three (3) year old child as a result of the mother abusing opiates and heroin with the child's biological father in the presence of the child to the extent that the mother could not adequately care for the child. ACS intervened and removed the child from the care and custody of the mother and the child was never returned to the mother.

The ACS investigation revealed that the mother admitted to snorting heroin, that the drug test she would be submitting to on January 11th, 2018 would result in a positive finding for opiate use, that she last used heroin on January 6th, 2018, and further admitted to allowing men to come

[140] Witness 1, 2, 3, 8, 11, 14 and 16, Exhibit 48.

in through the fire escape of the shelter at 1 a.m. which presented a safety risk for her three (3) year old child. The mother was indicated for inadequate guardianship and drug misuse.

On December 27th, 2022, Witness 11 spoke with staff at Garnet Health who informed Witness 11 that the baby, A.L., started to show signs of withdrawal, had minor tremors, was only sleeping one (1) hour in-between feedings, and had a NAS score of three (3). In speaking with the mother, she informed Witness 11 that she had not used cocaine during the pregnancy and only relapsed on December 25th, 2021, a day prior to giving birth to the child. Subsequent testing of the baby's meconium revealed that the baby tested positive for cocaine.

In a review of treatment records provided by Lexington Recovery Center, Witness 11 discovered that the mother had tested positive for drugs throughout her pregnancy, including for methadone, fentanyl, codeine, and morphine on September 9th, 2021, tested positive for fentanyl, methadone, morphine, codeine, and cocaine on October 22nd, 2021, tested positive for fentanyl methadone, morphine, and cocaine on October 25th, 2021, tested positive for fentanyl, methadone, morphine, and cocaine on December 10th, 2021, and tested positive for methadone as prescribed on December 16th and 23rd, 2021.

On December 29th, 2021, Garnet Hospital discharged the baby to the mother and father who were picked up by taxi and returned to their residence. Witness 11 later arrived at their residence, a trailer with holes in the ceiling and holes in the hallway floor which required Witness 11 to use caution when walking towards the bedroom where A.L. slept. In addition, the trailer had windows that were broken and covered with cardboard, and heat was only available in one (1) room of the trailer in the middle of winter. What is more concerning, the trailer potentially contained black mold. Witness 11 testified that these concerns regarding the heat were brought to

the Office of the County Attorney and the Office of the County Attorney stated that the heat was not a concern because the newborn, A.L. could not walk out of the room.

On January 4th, 2022, Witness 11 consulted with the Office of the County Attorney via Department email and asked whether any legal action could be taken pursuant to the enumerated safety concerns above. The Office of the County Attorney told Witness 11 that they were unable to take *any* legal action.

On January 5th, 2022, Witness 11 informed the Office of the County Attorney via department email that the mother was bringing in cold urine to her treatment provider and her urine was still testing dirty. The treatment provider requested that the mother provide a fresh urine sample on the 5th of January and the mother stated that she could not urinate. The provider informed the mother that they would take a swab instead and the mother ran out of the treatment clinic and would not stop despite efforts from staff and a counselor. Despite a clear indication of continued substance abuse, the Office of the County Attorney was unmoved and took no action with that information.

Despite all of the evidence presented to the Office of the County Attorney including the mother's previous indicated allegations of drug use in front of a former child who was removed from the mother only a few years earlier, information of serious drug use including fentanyl, cocaine, and morphine during the mother's third trimester of her pregnancy despite representations that she had only used once a day before the birth of the child, the child having been born with mild withdrawal symptoms, an NAS score of three (3), being positive for cocaine, the parents appearing impaired by drugs at the time they arrived at the hospital with the newborn, the mother's attempts to prevent detection of continued drug use while caring for the newborn, and the lack of appropriate heat and shelter due to holes in the ceiling, holes in the floor, broken windows covered

with cardboard and inappropriate heating during the dead of winter, the Office of the County Attorney denied the request for *any* legal action and told Witness 11 that there was not enough to pursue a neglect against the mother and Witness 11's above stated concerns were *minimal at best*. Without the court intervention requested by CPS the case is unfounded.

The members of the grand jury credit the testimony of these witnesses and find that the Office of the County Attorney's conduct is beyond the exercise of discretion within the confines of the legal profession and, their opinion, testified to by numerous witnesses that derivative neglect no longer existed as a legal theory exercisable before a court of competent jurisdiction. That opinion represented a reckless disregard of the duties of the Office of the County Attorney and, by virtue of their representation of DSS and CPS, their duties to protect the children of Sullivan County.

B. The Birth of a Subsequent Child, C.L., to Mother and Father

On January 12th, 2023, just twelve (12) months after the birth of A.L. ,. a CPS intake report was received by the State Central Register ("SCR") from Nurse 1 stating that the same mother had an additional child, C.L., and when C.L. was born they tested positive for cocaine. There was no indication of a plan for safe care for the child, no reports of prenatal care, and the mother refused to be drug tested. At the time of the report C.L. did not show any signs or symptoms of withdrawal.

On January 13th, 2023, a CPS intake report was received by the SCR from Nurse 2 alleging that the caretaker for the child acts negatively towards the child and the caretaker's current drug abuse seriously affects his/her ability to care for the child. Caseworker, Witness 8, contacted St. Luke's Hospital and the hospital reported that the baby had labored breathing, was jittery, grunting, and had nasal flaring.

CPS assigned Witness 8 to the case and Witness 8 reviewed the case file, including the previous positive toxicology for A.L. . Witness 8 testified that it appeared surprising that A.L. was not removed from the home initially, would have been removed under DFS Legal, and in their experience Witness 8 would have requested removal of the A.L. from the parents upon the initial positive toxicology.[141] After receiving the initial call regarding the positive toxicology for C.L., Witness 8 responded to the maternal grandmother's residence and the maternal grandmother informed Witness 8 that A.L. was with the paternal grandmother in New Jersey. Witness 8 decided to attempt to locate A.L. and the parents. Witness 8 tried to locate the parents with police assistance without any results. After having no luck, Witness 8 returned to the maternal grandmother's residence with the police and discovered that the maternal grandmother was hiding the child, A.L. and the child's father in the apartment. Subsequently, the parent's reported to Witness 8 that they were living in the Village of Liberty and upon arriving at the residence Witness 8 discovered that the eight month old child, A.L. had no crib, no bed, no high chair, no diapers, or any other items to adequately care for a child at that residence. Witness 8 testified that this conduct bolstered their concerns and belief that a removal of the child C.L. was appropriate. Prior to making a determination on the case Witness 8 a new case worker was assigned.

On January 18th, 2023, a CPS intake report was received by the SCR from Social Worker alleging that the child, C.L. was suffering from withdrawal symptoms, irritability, poor feeding, the mother had a history of drug abuse, and there was no known safe plan of care for the baby.[142]

On January 23rd, 2023, Caseworker 11 spoke with Social Worker 1 who reported that the baby, C.L., was suffering from increased tremors and stiffness, the baby had been throwing up, and was fussy. Witness 11 also spoke with Doctor 1 who reported that the child's mother tested

[141] See Grand Jury Testimony of Witness 8.
[142] Grand Jury Exhibit 48.

positive for cocaine, morphine, marijuana, and methadone. Doctor 1 reported to witness 11 that the mother had stated that she had done four (4) lines of heroin and Doctor 1 expressed to Witness 11 that the baby *should not* be going home with the parents and should instead be going into foster care.[143] In addition, a Doctor from Westchester Medical Center contacted Witness 15 and begged the Witness to try to figure out anything that they could do to prevent the both children from going back to their parents. The Neonatologist informed Witness 15 that C.L. was the worst case of NAS withdrawal that she had ever seen.

On January 23rd, 2023, Witness 11 conferenced the matter with Witness 3 who informed Witness 11 that the matter would be conferenced with the Office of the County Attorney about filing a petition for removal of both children, A.L. and C.L.. Subsequent to this conference, on the same date, Witness 3 called the Office of the County Attorney and conferenced the case requesting a petition for removal of both children. After conferencing the case, the Office of the County Attorney agreed to file a petition for removal of both children and the petition would be handled by that office. Witness 3 emailed the Office of the County Attorney to begin the petition sometime after 5 p.m. on January 23rd, 2023. The following day, the Office of County Attorney responded to Witness 3 via email and indicated that they did not have time to work on the petition requested.[144]

The following Wednesday, on January 25th, 2023, Witness 3 met with the Office of the County Attorney in person who informed Witness 3 that a removal would not proceed because A.L. was still living in the home and that the one and half year old was living safely in the home despite evidence that the parents continued to abuse narcotics. A copy of Witness 3's schedule was entered into evidence as Grand Jury Exhibit 77, denoting a meeting with the Office of the

[143] Id.
[144] Grand Jury Exhibit 48.

County Attorney at 11 a.m. on the 23rd. Despite Witness 3 arguing that the mother's prior history existed and no changes were made to the parents' behavior, arguing for a derivative neglect petition, the Office of the County Attorney stated that they would not file the petition for removal of the children.

On January 31st, 2023, a CPS intake report was received by the SCR from Concerned Citizen 1 reporting that the mother and father used heroin and crack to the level of impairment while caring for A.L., the only source of heat provided in the home was a space heater, and the family was not often home during the daytime.

On February 2nd, 2023, Caseworker, Witness 11, spoke with Nurse 3 from St. Luke's Neonatal Intensive Care Unit who informed Witness 11 that the baby appeared to be doing better, was still irritable during sleep time, and had tested positive for methadone, cocaine, and fentanyl.

On February 5th, 2023, a CPS intake report was received by the SCR from Concerned Neighbor 1 who reported that the mother and father were abusing heroin while caring for A.L. and, in addition, two (2) other unrelated individuals abused crack-cocaine in the home while A.L. was present. Concerned Neighbor 1 stated that CPS had been in the home previously and nothing had changed.

The following day, on February 6th, 2023, Witness 11 spoke to Social Worker 1 who informed Witness 11 that C.L.'s meconium (newborn feces) tested positive for morphine, fentanyl, and benzodiazepines. These results clearly revealed drug use during the third trimester of pregnancy and C.L.'s Neonatal Abstinence Syndrome score was increasing from 7 to 11 and to 14 on January 13th, 2023. Lastly, Social Worker 1 informed Witness 11 that the mother called multiple times and the mother appears as if she is under the influence of drugs or alcohol.

On February 6th, 2023, Witness 3 met with the Office of the County Attorney in person and again requested to file a removal petition for A.L. and C.L. Despite having knowledge that the mother's child A.L. previously tested positive for cocaine at birth, all the attendant circumstances surrounding that case, the previous removal of the mother's child for substance abuse, baby C.L.'s positive toxicology for morphine fentanyl, and benzodiazepines, and C.L.'s high NAS, the Office of the County Attorney stated that they would not file the petition for removal and, instead, advised Witness 3 to institute a safety plan. The meeting is documented in Exhibit 48 of the Grand Jury on an item identified as "Legal Consult" and further supported by the institution of a safety plan on February 6th, 2023, contained within the same Exhibit.

The same day, Witness 11 entered into a safety plan with mother and father. The contents of the safety plan stated that "Under no circumstances will [mother or father] engage in the usage of any illegal substance or misuse any prescribed medication. [Mother and Father] will remain sober while caring for and being in the direct presence of their children A.L. and C.L. [Mother and Father] will ensure A.L. and C.L. are seen by a pediatrician and all recommendations are followed. [Mother and Father] will continue with their drug treatment and have no positive drug screenings and follow through with all recommendations. [Mother and Father will fully cooperate with Sullivan County CPS, work with Preventive Services, Public Health Nursing and all service providers placed in the home until further notice." The safety plan further stated that it was up to [Mother and Father] to follow the specifics of the safety plan and Sullivan County DFS will continue to monitor [them]." The document was signed by mother, father, and Witness 11 on February 6th, 2023.

During the visit, Witness 11 reported that both parents appeared sober and further reported that they were working through treatment for their addictions.

On February 24th, 2023, CPS indicated allegations of inadequate guardianship and parental drug use against the mother due to the preponderance of the evidence established during the investigation. Nonetheless, the case was closed without court supervision or mandated services because the Office of the County Attorney informed CPS they could not file a petition to remove the children despite multiple requests.

On May 2nd, 2023, A.L. allegedly died while in the custody of the mother and father in a motel room at the Knights Inn as a result of ingesting lethal amounts of fentanyl combined with xylazine. The morning following the death of A.L., Witness 13, while in the County Attorney's Office, overheard a conversation between staff from the Office of the County Attorney and another employee of the County Attorney's Office. Witness 13 testified that they heard an employee make a joke, in reference to the A.L. investigation, insulting A.L. 's siblings' name, laughed and then stated, "My mom has crowned me a few times" and laughed again.

C. Comment Comparing CPS to "Countries like Germany before WW II"

The death of A.L. gained national media attention and many comments were made critical of CPS's alleged failure to intervene to safeguard the child, A.L. Following the public media attention surrounding the death of A.L., Witness 3 emailed the Office of the County Attorney in frustration regarding the case and expressed that the Department was getting criticized heavily in the public[145] and that CPS " . . . did not feel that this [referring to A.L.] was a safe situation but a ticking time bomb . . . OCFS thus far hasn't found fault in procedure but questions why [CPS] didn't file a petition. [CPS] explained [they] did consult but did not have enough."[146] The Office

[145] Witness 11 further testified that social media comments blame CPS and the caseworker for the death of A.L.
[146] Grand Jury Exhibit 80.

of the County Attorney responded, ". . . [m]uch of treatment is living with a lie and if we wholesale remove children that will put us in the same position as countries like Germany before WW II."[147]

The members of the grand jury find the Office of the County Attorney's statements to be unprofessional and an apparent comparison of CPS's desire to remove children to Nazi Germany's removal of children from homes without consent and the horrific implications of such removals. The members of the grand jury further find that these comments are demonstrative of a trickle pattern of behavior incongruent with the Office of the County Attorney and demonstrated a wholesale misunderstanding of the objectives of its client, DSS.

The grand jury finds the evidence provided by Witness 3 and Witness 11 evidences that at least three (3) requests were made to the Office of the County Attorney requesting the removal of A.L.

The grand jury finds pursuant to the credible testimony that the Office of the County Attorney needed to be consulted for approval before a removal and a removal could not functionally be completed without the County Attorney's Office moving forward with a petition within seventy-two (72) hours of an emergency removal; otherwise the child would be returned to their home. This was demonstrated by the credible testimony and documentary evidence presented to the grand jury whereby the Office of the County Attorney directed the return of children removed by the Commissioner from their homes without prior approval.[148]

The grand jury finds Witness 13's testimony credible and finds the Office of the County Attorney's comments regarding the sibling of a newly deceased eighteen (18) month old child to be wholly inappropriate, unprofessional, and illustrative of a pattern and practice of failing to take

[147] Id.
[148] Grand Jury Exhibit 47.

the safety of the children of Sullivan County seriously. Moreover, the grand jurors find that these comments demonstrate a display of the lack of integrity in the Office of the County Attorney.

The credible testimony of Witness 13 and the supporting documentary evidence provided[149] showed that CPS indicated reports with respect to the investigation of C.L. and the mother had previously had an indicated report out of an investigation from ACS which was documented in the file and also presented directly to the Office of the County Attorney as a basis for legal action.

As a result of the conduct of the Office of the County Attorney, DSS amended their policy with respect to entering notes about legal consultations. Former DSS policy required the employee to enter "Legal Consult" in the notes with no information surrounding the consultation. However, since that time DSS requires the caseworker to place details inside of the CONNX notes to document Department's requests and decisions made by the Office of the County Attorney.[150]

Moreover, the members of the grand jury find that the credible evidence and testimony demonstrates that the Office of the County Attorney has a demonstrated and documented history of taking unnecessary risks by placing children into dangerous situations in wholesale reliance safety plans built upon empty promises by individuals with demonstrated histories of non-compliance. That practice makes this tragedy predictable, this home, like many, was a ticking time bomb. If the Office of the County Attorney would have moved for a petition as requested by CPS and a removal was granted, A.L. would not have been located in the home at the time of A.L's death because the parents were still abusing narcotics at the time of C.L.'s birth and their continued drug abuse would have prevented the return of A.L..[151]

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[149] Grand Jury Exhibit 48.
[150] Grand Jury Testimony of Witness 2.
[151] Grand Jury Testimony, Witness 11.

VI. OUTLOOK[152]

On July 31st, 2023, a father residing in the Knights Inn was caring for his two children and the father was known to CPS as a drug user, participating in a treatment program, regularly refused caseworkers access to see the children, his toxicology reports had become progressively more serious with positive results for fentanyl, and he had refused face to face contact with CPS for several days. CPS had previously requested an access order for this father to gain access to the residence. A CPS on-call worker responded to the father's residence at the Knights Inn and he refused to open the door and allow the worker access to the children. After internal consultation, Witness 2 requested that the Office of the County Attorney acquire an access order.

On July 31, 2023, Police Officer, Witness 20, responded to the Knights Inn in Liberty to assist CPS in removing children and to gain access to the room via an access order granted by Sullivan County Family Court. Witness 20 contacted the Office of the County Attorney to ask what authority the order gave Witness 20 and CPS staff with respect to the subject at the Knights Inn. The Office of the County Attorney explained to Witness 20 that the access order granted CPS and the Police Department the authority to enter the subject's home to inspect for evidence of abuse or neglect and to inspect the children for evidence of abuse or neglect. The Office of the County Attorney explained that in the event the subject did not comply with the access order Witness 20 could not use force and instead should slide the order underneath the subject's door and to follow up the next day to file for an arrest warrant for the subject to enter the subject's residence.[153]

The Office of the County Attorney did not consult the Department and Witness 2 was notified by Witness 1 that the Office of the County Attorney explained to Witness 20 that Witness

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[152] Witness 20. Exhibit 69.
[153] Grand Jury Testimony, Witness 20.

20 should leave the order under the door and return the next day. When Witness 2 learned of this, Witness 2 explained that they requested the access order because two small children were left in a room with the sole caretaker who was abusing fentanyl at the Knights Inn, and the Liberty Police Department should not take the action requested by the Office of the County Attorney. Several hours later after waiting outside of the door, CPS was granted access to the room and removed the children. Witness 2 testified that this situation was extremely disturbing that the Office of the County Attorney would recommend that the police officer slide an order under the door and return in the morning with knowledge that someone had not had face to face contact with CPS for several days who was abusing fentanyl at the Knights Inn, the same location where a sixteen month old child, A.L. had died of a fentanyl overdose almost three months earlier.

The members of the grand jury find the testimony of Witness 2, 3, and 20 to be credible and further find that the County Attorney's Office's conduct demonstrates a failure to learn from flawed decision making that permitted the death of A.L. In addition, the Office of the County Attorney's conduct continues to demonstrate a breach of its duty to seek the objectives of its client. Such conduct if not stopped by Witness 2 may have led to poor consequences, would have placed the children located inside of the motel room at a continued risk of imminent harm, and would have nullified DSS's request for an access order.

VII. FINDINGS

The members of the grand jury find that the legal representation provided to CPS falls short of the high quality work those professionals deserve and that best serves Sullivan County. The members of the grand jury wish to propose the following recommendations for legislative, executive or administrative action in the public interest based on our stated findings above:

1. The County Attorney's Office should be divested of all responsibility for CPS's legal representation and DFS's Legal Department should be reinstituted as it existed previously. It is in the public interest to have a CPS with the ability to fulfill its charge to protect children without inhibition from legal representation that has gone awry.

2. There should be an annual reporting process created for CPS as to the quality of legal representation the workers understand they received in a given year. This process should be anonymous and without fear of retribution and published each year for public consumption. This is in the public interest because it should prevent any future situations in which poor legal representation is permitted to negatively impact the safety of Sullivan County's children for over 2 years. The increased transparency, we feel is absolutely necessary for the protection of CPS's interests given the necessary secrecy surrounding their activities.

3. There should be a complete rethinking of the use of motels to house vulnerable populations in Sullivan County. The amenities provided are insufficient to meet the needs of those most likely to face instability, particularly those with substance use disorders bringing home a newborn child. Specifically we would recommend a program where families could work their way to sobriety and their own living quarters. Perhaps there is a way to utilize the LandBank, foreclosures, USDA rural grants, or other public-private partnerships to expand access to affordable housing in Sullivan County. At the very least, we feel that there should be Narcan and

Fentanyl test strips publicly available at any hotel or emergency housing DSS may continue to utilize in the short term. We suggest a legislative subcommittee be convened to study this issue in detail and take into consideration our recommendations. This would be in the public interest because Sullivan County has the highest per capita rate of children born addicted in the State of New York, and anything we can do to push those numbers down is critically important to the success of Sullivan County and its children in the future.

5. We recommend that Sullivan County create its own drug treatment facility, a service for which our citizens must now transit out of county. The opportunity exists in this Crossroads of the Catskills to create a destination facility that might also bring construction jobs, tourism, and a healthier future for all in the community. This would be in the public interest for the same reasons we should no longer be utilizing the hotel-as-shelter format.

6. We recommend that CPS obtain the ability to drug test their clients in-house. This would eliminate much of the consternation experienced by that agency in getting substance use treatment records and would enable real time evaluation and proof as to a caregivers ability to appropriately provide for a child. This would be in the public interest because parents should not be able to evade responsibility for their neglectful acts based solely on the treatment provider's lax testing policies or inability to answer a phone call from CPS.

7. We recommend the creation of a legislative subcommittee to work to facilitate local Sullivan County hospitals adopting the double-doctor override for a maternal refusal to accept drug testing at delivery and refusal to permit drug testing of an infant-even in withdrawal. This is in the public interest as a way to ensure that our infant addiction statistics is not suffering from an underreporting of cases, thus permitting us to allocate an appropriate amount of resources to meet this challenge head on.

VIII. CONCLUSIONS

The members of the grand jury were presented with testimony pertaining to the conduct of legal work on behalf of the Sullivan County Department of Social Services. It is the additional finding of the grand jury that the staff of DSS and CPS work in tireless good faith to protect the families of Sullivan County from substance abuse, maltreatment, neglect, abuse, violence, criminal activity, and mental health issues.

The tragic death of A.L. could have been prevented. The experienced professionals in CPS brought their legitimate concerns to the Office of the County Attorney on this and every investigation of child abuse and neglect explored by this grand jury. The evidence established the sad reality that children are at risk all around this county, but the testimony before the grand jury also demonstrated that DSS should be proud of the work it carries out on a daily basis for this community.

CPS employees possessed a keen understanding of their responsibilities, knowledge of their community, and a level of expertise in their craft. These employees exercised their judgment professionally and the evidence established that these caseworkers requested removals on numerous cases not to tear apart families but to safeguard these children and reunite them to create a stronger familial unit. Sadly, the quality of legal representation provided to DSS has stood in between DSS, CPS, and their obligation to protect the children of this county. This has endangered many lives and the lack of cooperation with DSS and CPS, their workers, and their administrators clearly showed that their legal representation was not representing their interests.

Failures to fulfill obligations to a client resulted in the dissemination of public misinformation. The grand jury finds that despite the public comments, the overwhelming evidence strongly supported the findings in this report and the findings represent a call to the public

to resolve this issue, to restore integrity to this county, and to once again protect the people of our community and those who show up to work each day to do the same. This County deserves a CPS which is represented with honesty, integrity, compassion, and who will work cooperatively every day to achieve the protection of our children.

At a Session of the Special Term, Term of the Court, Sullivan County, New York, held in and for the County of Sullivan, at the Courthouse, in the Village of Monticello, New York, on the day of January 3, 2024.

COUNTY COURT OF THE STATE OF NEW YORK
COUNTY OF SULLIVAN: HON. JAMES R. FARRELL

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IN THE MATTER OF THE EXISTENCE OF THE CRIMINAL TERM 5A OF THE COURT OF THE COUNTY OF SULLIVAN, NEW YORK AND ITS GRAND JURY WHICH COMMENCED APRIL 26, 2023 AND WAS EXTENDED TO JANUARY 16, 2024

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Order

The Term 5A Grand Jury appearing before this Court on this date by affidavit of its Foreperson, and having been advised it adopted a Grand Jury Report pursuant to CPL § 190.85(1)(c) that proposes recommendations for legislative, executive, and administrative action in the public interest based upon stated findings, and said Grand Jury Report is not critical of an identified or identifiable person, and having requested this Court to accept and file said report as a public record; and

WHEREAS, the Court has reviewed the transcripts of the proceedings and reviewed the exhibits admitted into evidence and determined that the Grand Jury Report, as the Court has ordered it approved, is based upon facts revealed in the course of an investigation authorized by CPL § 190.55 and is supported by a preponderance of the credible and legally admissible evidence; and

WHEREAS the Grand Jury Report

At a Session of the Special Term, Term of the Court, Sullivan County, New York, held in and for the County of Sullivan, at the Courthouse, in the Village of Monticello, New York, on the day of January 3, 2024.

COUNTY COURT OF THE STATE OF NEW YORK
COUNTY OF SULLIVAN: HON. JAMES R. FARRELL

----------X

IN THE MATTER OF THE EXISTENCE OF THE CRIMINAL TERM 5A OF THE COURT OF THE COUNTY OF SULLIVAN, NEW YORK AND ITS GRAND JURY WHICH COMMENCED APRIL 26, 2023 AND WAS EXTENDED TO JANUARY 16, 2024

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Order

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WHEREAS, the Court has reviewed the transcripts of the proceedings and reviewed the exhibits admitted into evidence and determined that the Grand Jury Report, as the Court has ordered it approved, is based upon facts revealed in the course of an investigation authorized by CPL § 190.55 and is supported by a preponderance of the credible and legally admissible evidence; and

WHEREAS, the Grand Jury Report proposes recommendations for legislative, executive, or administrative action in the public interest based upon stated findings and the Grand Jury Report is not critical of an identified or identifiable person; and

NOW, upon the request of said Grand Jury, and upon the application of BRIAN P. CONATY, District Attorney for the County of Sullivan, it is hereby

ORDERED, that the Grand Jury Term 5A Grand Jury Report pursuant to CPL § 190.85(1)(c) be accepted for filing as a public record.

Dated: January 3, 2024
Monticello, New York

HON. JAMES R. FARRELL
County Court Judge