VIRGINIA:

IN THE CIRCUIT COURT OF THE COUNTY OF HENRICO

IN RE: Investigation Regarding Allegations of Criminal Conduct at Henrico Doctors' Hospital (Forest) in Henrico County

FINAL REPORT OF THE FINDINGS AND RECOMMENDATIONS MADE BY THE SPECIAL GRAND JURY

Came this day, January 9, 2026, the Special Grand Jury, who pursuant to Virginia Code §19.2-207, was convened to investigate allegations of criminal conduct at Henrico Doctors' Hospital. This report includes the findings and recommendations made by this body.

I. Executive Summary

On January 2, 2025, Defendant Erin Strotman ("Strotman"), a nurse in the Neonatal Intensive Care Unit (the "NICU") at Henrico Doctors' Hospital- Forest ("HDH")[1], was arrested for child abuse crimes after review of video footage showed her engaged in concerning treatment of an infant during her employment in October/November 2024. Further investigation and review of video footage showed Strotman engaging in a pattern of abuse involving additional victims. Strotman was charged with abuse and neglect charges involving these new victims (the "2024" Cases.) The 2024 Cases were especially concerning because Strotman was a person of interest when there was a similar cluster of injured children in 2023. In 2023, four children in the HDH NICU suffered fractures that were concerning for non-accidental trauma (the "2023 Cases"). In response to the 2023 Cases, Strotman, among others, was placed on administrative leave and was not returned to work at the HDH NICU until September 2024.

Because of concerns about the 2023 Cases and their status, this Special Grand Jury was

[1] HDH-Forest is the Forest campus of Henrico Doctors' Hospital, located at the intersection of Forest Avenue and Skipwith Road in Henrico County, Virginia. The hospital's corporate parent is HCA Healthcare, Inc., headquartered in Nashville, Tennessee.

convened to investigate regarding allegations of criminal conduct at HDH (the "Special Grand Jury"). The Special Grand Jury was assembled in final form by January 21, 2025, and spent nearly four (4) months engaged in the collection and review of evidence from the 2023 Cases and the 2024 Cases. On May 2, 2025, the Special Grand Jury returned indictments against Strotman involving the 2023 Cases. An additional case from 2022 was uncovered and charges were filed against Strotman for that victim, although the evidence for that matter was not examined by the Special Grand Jury. The 2022 indictment was returned by the Grand Jury convened in Henrico County's ordinary course of business. In total, there were nine (9) victims for a time that began in 2022 and ended in 2024.

Through its investigation and the taking of evidence, both testimonial and documentary in nature, the Special Grand Jury noted significant failures in safeguards and protections for Strotman's victims at various levels.

II. The Special Grand Jury's Procedural History

On December 27, 2024, in response to a Motion to Empanel a Special Grand Jury Pursuant to the Code of Virginia §19.2-206 et. seq. filed by the Honorable Shannon L. Taylor, Commonwealth's Attorney for the County of Henrico, the Honorable Rondelle D. Herman, Circuit Court Judge for Henrico County, convened the Special Grand Jury for the stated purpose of "investigating and reporting on any condition that involves or tends to promote criminal conduct by employees of Henrico Doctors' Hospital (Forest), located at 1602 Skipwith Road, Richmond, VA, 23229, in Henrico County." The Order of this Court authorized the Special Grand Jury to investigate and report upon the conduct of the employees assigned to and of any persons who accessed the NICU from July 29, 2023, to the present day, as to "whether any individual's conduct involves or tends to promote criminal conduct."

On January 13, 2025, Judge Herman conducted the voir dire required by Virginia Code §19.2-207 to review the qualifications, indifference, and disinterest of each potential Special Grand Juror. After this voir dire was conducted, 11 individuals were selected to serve as Special Grand Jurors and were found to be qualified, impartial, and disinterested in the subject matter and the outcome of the investigation. Judge Herman also selected a Special Grand Jury foreperson. On January 14, 2025, Judge Herman entered her initial Order.

As the Special Grand Jury met, witness testimony was taken, including testimony taken from an expert retained by the Special Grand Jury. Moreover, a series of subpoena duces tecum were issued for documents in possession of HDH. Each of these document requests was responded to; however, privilege of various kinds was asserted by HDH. During its work, the Special Grand Jury found probable cause for the return of indictments against Strotman related to the 2023 Cases.

On June 11, 2025, due to the extensive scope of the Special Grand Jury's work, Judge Herman extended the term of the Special Grand Jury for another six (6) months. This report, along with the returned indictments against Strotman, is the culmination of the work of the Special Grand Jury. This report, taken together with the indictments, represents hundreds of hours of work on the part of this Special Grand Jury.

III. Summary of Evidence[2]

On September 21, 2023, the CEO of HDH, Ryan Jensen, and HDH's VP of Quality Denise Weisberg contacted Henrico County's Child Protective Services ("CPS") to make report of concerns for non-accidental trauma inside of HDH's NICU. This initial report identified four (4) infants in the HDH NICU who had unexplained and concerning fractures. Sarah Wilson, an investigator from CPS was assigned to investigate along with Sgt. Matthew Fitzer from Henrico County Police Division ("HCPD"), (collectively the "2023 Joint Investigators"). This joint investigation (the "2023 Joint Investigation") commenced on September 22, 2023. CPS has the authority to implement a safety plan to protect children while any joint investigation is underway, which it did. A CPS safety plan is intended to be temporary in nature and is only implemented while or during the course of any joint investigation. Investigations are statutorily mandated to be completed in ninety (90) days.

The injuries to the four identified victim children were of immediate concern to the 2023 Joint Investigators. As they commenced the 2023 Joint Investigation, Investigators learned that HDH discovered the first fracture of the first victim child, whose initials are Z.M., on August 5, 2023, almost seven (7) weeks before HDH notified CPS of the injury. Baby Z.M. had a closed, displaced transverse fracture of the left radius. The injuries to the second infant, baby T.M., were discovered on August 16, 2023. Baby T.M. had a radial fracture, a fracture of the ulna, a right rib fracture, a distal femoral fracture, a left radial fracture, and bruising. On September 3, 2023, injuries were discovered on the third infant, baby M.L. This infant had bruising and a left radial bucket fracture. Finally on September 3, 2023, a non-displaced fracture of the left tibia fracture was found on the fourth baby, baby N.H.

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[2] Detailed summaries of testimony from each of the witnesses are provided in the Exhibits appended to the end of the report.

Sometime after August 5, 2023, and before September 21, 2023, and long before CPS was ever notified, HDH retained a law firm to conduct what was described as a complete internal investigation into the injuries suffered by the four 2023 victim infants. This internal investigation included interviews with approximately twenty (20) hospital staff members and a complete review of the hospital staffing records. HDH also retained its own expert, a well-respected pediatric orthopedist, to review the records of these infants. One of HDH's specific responses to its own internal investigation was the placement of a nurse named Erin Strotman ("Strotman") on what HDH referred to as "administrative leave". At the time of this administrative action, Strotman's employment history with HDH was relatively brief. She was hired by HDH in September of 2019 and was transferred to work in the NICU at HDH in May of 2022.[3]

As the 2023 Joint Investigation commenced, it was quickly determined that none of the victims' injuries were the result of the birth process. The Joint Investigators also learned that Dr. Gerry Reece, a well-respected radiologist, was the first person to identify these injuries as concerning after reviewing radiological studies of the 2023 victim children. Dr. Reece told HDH that these injuries were concerning non-accidental, inflicted injury by September 11, 2023, when Dr. Reece reported his concerns to the Chief Medical Officer of HDH, Dr. Ajit Singh. The Joint Investigators also learned that Dr. Reece prepared a document referred to as the "Windows of Opportunity" document that established when the observed injuries of the 2023 victims would have been caused based on the observed healing of the various injuries. The Joint Investigators learned Strotman was one of the identified people who had contact with all the 2023 victim infants and that was the reason that HDH placed her on administrative leave.

With the backdrop of an already-completed internal HDH investigation, the 2023 Joint Investigators worked diligently at HDH and conducted their own witness and document reviews.

[3] Strotman's employment with HDH was terminated on or about January 2, 2025.

Like the internal HDH interviewers, they interviewed everyone who they believed might have had information about the cause of these fractures, including HDH administrators, nurses, respiratory therapists, neonatologists, and radiologists. As part of their investigation, the 2023 Joint Investigators also consulted with Robin Foster, MD, a board-certified Child Abuse Pediatrician. Dr. Foster was asked to review relevant records for the 2023 victim infants. Dr. Foster's opinion was that these injuries were non-accidental and concerning for abuse. Her opinion aligned with Dr. Reece's already offered opinions.

The 2023 Joint Investigators learned that the other reviewing radiologists shared Dr. Reece's concerns. Despite these opinions, HDH, through counsel, nevertheless ratified the position that the observed injuries could have been caused by metabolic bone disease coupled with ordinary handling. This position was also asserted in interviews conducted by the 2023 Joint Investigators with the treating NICU neonatologists, who uniformly told the 2023 Joint Investigators that they believed that the injuries, while unusual, could be explained by reasons other than inflicted trauma. Dr. Reece nevertheless remained unequivocal that what he was observing was inconsistent with normal handling and metabolic bone disease. This opinion was the same as Dr. Reece told Dr. Singh on September 11, 2023.

The 2023 Joint Investigation was materially limited by the way HDH provided care to NICU patients in 2023. In 2023, while specific nurses were assigned to specific NICU patients, the HDH NICU nursing staff employed a team model for care where nurses who were not assigned to babies were nevertheless providing care to those infants. HDH had no reliable system for tracking who provided nursing care to each infant. Moreover, the 2023 Joint Investigators quickly learned that a large team of professionals and staff were in and out of these NICU rooms all day with virtually no documentation of who was providing care. While the 2023 Joint Investigators

were able to develop suspects in 2023, it became obvious that many unknown HDH employees and subcontractors had access to the 2023 victim children. Additionally, there was no video inside of the NICU although there were video systems in other areas of HDH.

At the end of the 2023 Joint Investigation, the Joint Investigators were unable to identify a single suspect to charge with any crime involving harm to the 2023 victim infants. Despite the nature and number of injuries and the opinions offered by Drs. Reece and Foster, the Joint Investigators were unable to identify one sole individual upon whom responsible could be placed. For this reason, Sgt. Fitzer and the assigned prosecutor from the Henrico County Commonwealth's Attorney's Office notified the families of the 2023 victim children that no prosecutions would take place. Despite this prosecutorial declination, CPS made a finding of abuse and neglect for these involved infants. The case was "Founded, Level 1 for physical abuse."[4] Because the abuser could not be identified with specificity, the abuser was identified as an employee of HDH. HDH disputed the conclusion that the abuser was an HDH employee.

During the investigation of these fractures, a parallel investigation was underway. Failure to report suspected physical abuse and neglect of a minor child is a non-jailable misdemeanor in the Commonwealth of Virginia.[5] It became obvious to both the 2023 Joint Investigators and the reviewing prosecutors that there was no system in place for effective CPS notification at HDH. Well-meaning care workers including physicians and nurses all believed they had satisfied their requirements by notifying personnel in HDH's internal reporting chain. Reviewing prosecutors believed there would be significant proof problems in achieving a successful result. Instead, the Commonwealth's Attorney's Office chose an opportunity to effect a long-term change within HDH to educate its personnel and to improve safety conditions for NICU patients and reached an

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[4] There is a difference in the standard of proof required to make a finding through the CPS system, where the standard is lower than beyond a reasonable doubt which is the standard of proof to support a criminal conviction.
[5] See Code of Virginia Section 63.2-1509 for the statutory language that underpins this charge.

agreement with HDH. As discussed with the Commonwealth's Attorney's Office, HDH installed video camera systems in every patient room in the NICU. Further, in exchange for not charging anyone associated with HDH with Failure to Report, HDH agreed to conduct a HDH-wide training regarding child abuse and CPS reporting requirements for all personnel with contact with NICU patients.

The 2023 Joint Investigation was closed and concluded when new injuries of concern were reported in November, 2024. On November 21, 2024, HDH notified CPS that there were concerns for non-accidental injury for a patient in the NICU, a baby whose initials are Y.H. Baby Y.H. had a constellation of injuries, including an impacted distal left femoral metaphyseal fracture, a right proximal fracture, and possible rib fractures. In contrast to the delayed CPS reporting in 2023, reporting of this incident was made by HDH administrators immediately, which is evidence that the training that was part of the agreement between the Henrico CA's Office and HDH achieved its intended purpose of child protection. A 2024 Joint Investigation immediately commenced on November 22, 2024 and a new safety plan was immediately put into place. Det. Megan Lynch was assigned from HCPD's Special Victims' Unit and Rochelle Burrell was assigned from CPS (collectively the "2024 Joint Investigators").

In the 2024 Joint Investigation, the 2024 Joint Investigators had a material advantage that the 2023 Joint Investigators did not have: high-quality video surveillance cameras had been installed in each patient's room in the NICU. Unfortunately, no one at HDH told the 2024 Joint Investigators that Strotman, one of the chief suspects from the 2023 Joint Investigation, was placed back on administrative leave by HDH almost contemporaneously with the discovery of the fracture to Baby Y.H.

Dr. Foster, the board-certified Child Abuse pediatrician who was consulted in the 2023

Joint Investigation was asked to consult again in November 2024 in the matter involving Baby Y.H. Dr. Foster initially thought that because of the observed swelling of the leg that the injury was acute and that it had to have been caused within 24-48 hours before it was initially observed. That would have been great for the 2024 Joint Investigators because it would have limited the scope of video review to a very narrow window, but subsequent radiological studies dispelled the initial belief that the injury was acute. At that point, the 2024 Joint Investigators realized that they would need to do extensive video review to try to determine the genesis of these injuries.

Despite immediately contacting CPS in 2024, HDH failed to immediately provide the 2024 Joint Investigators with complete information regarding protective actions that HDH took in 2024. Not only did HDH fail to disclose that they immediately placed Strotman back on administrative leave, HDH did not disclose to the 2024 Joint Investigators that Strotman was the only employee who was required to complete four shifts with a preceptor before she was permitted to work independently when she was returned to work on September 17, 2024. This is significant because there were no similar injuries to any NICU infants during the entire time that Strotman was out of work between August 2023 and September 2024.

The extensive in-room video review that needed to be completed as part of the 2024 Joint Investigation was not without its challenges. While the HDH in-room video was of very good quality, actions taken by HDH out of concern for the privacy of nursing mothers limited its efficacy. All the recordings all had two large black boxes on the screens to cover the chairs that mothers were using to nurse that could not be removed. This presented obvious problems as the 2024 Joint Investigators conducted their video reviews: nurses were often sitting in these chairs to provide care so that nursing care could not be observed. The 2024 Joint Investigators started their witness interviews and their review of records, including documents related to patient care

scheduling, but everyone involved in the 2024 Joint Investigation believed that the video review was key to solving this case and there was concern that these black boxes could be a significant impediment.

The 2024 Joint Investigators were working on reviewing the HDH in-room video footage on December 17, 2024, when another CPS notification came in for Baby L. M.-B. Baby L. M.-B. was preparing to be discharged when a series of diffuse fractures were discovered. Specifically, this child had fractures to the distal right femur, the proximal right tibia, the distal left femur, the proximal left tibia, the distal right ulna, the proximal left ulna, the distal right radius, the distal left radius, the left third metacarpal, and diffuse rib fractures. The 2024 Joint Investigators knew to immediately request HDH in-room videos from the prior six weeks because of the work the Joint Investigators were already doing on the Y.H. case. Dr. Foster was consulted and she offered the opinion that Baby L. M.-B.'s injuries were concerning for non-accidental injuries.

Finally, as this investigation continued, on December 24, 2024, an additional case alert came in for a third infant, Baby H.W., who had a single, healing rib fracture. The offered history was that this child had an incident of "vigorous stimulation" during a period of apnea that caused this fracture.

Fortunately, the 2024 Joint Investigators finally found helpful evidence in the form of a concerning video between Strotman and Baby Y.H. When discovered, it was immediately obvious to the 2024 Joint Investigators that the demonstrated behavior was short of the accepted standard of nursing care, an opinion that was ratified by Dr. Foster. The video was also shown to Lisa James, HDH's nurse trainer for the NICU, who also offered the opinion that the demonstrated behavior was inconsistent with appropriate nursing care.

As video continued to be reviewed, more instances of Strotman's concerning care were

documented, not only of baby Y.H., but baby L. M.-B. as well. It was also observed that Strotman's treatment of the infants was materially worse when she was alone than when she was working with someone else. It was also documented that Strotman knew that video cameras were on and recording her behavior. Strotman was the only caregiver displaying behavior of concern at any time. It is notable that reviewers from VDH, CPS, HDH, and HCPD all reviewed video of care that took place in the NICU during the relevant time periods and Strotman and Strotman alone was the only caregiver who concerned any of these reviewers. Additional review of other video of Strotman working with other infants revealed concerning behavior with one other infant.

As part of the 2024 Joint Investigator, Det. Lynch reviewed Strotman's employment history and there was nothing of particular concern. Strotman's annual performance reviews were unremarkable. She had an associate's degree, not a bachelor's degree, but that was all that HDH required. She was placed on administrative leave in August 2023 but by October 3, 2024, she had completed all the requirements placed on her for return to work, including required education on the NICU's Fragile Bone Protocol, and the child abuse training implemented by HDH as a result of the 2023 Joint Investigation per its agreement with the Henrico County Commonwealth's Attorney's Office.

A review of the onboarding she received when she transferred into the NICU is also unremarkable. She completed all the training required by HDH's NICU, training that was judged to be adequate by experts who reviewed it. No one had any concerns in either 2023 or 2024 about the training that Strotman had received.

Based on the reviewed videos of patient care and the opinions offered by Dr. Foster, Det. Lynch sought warrants for the harm caused to Baby Y.H. Strotman agreed to a post-Miranda interview on January 2, 2025. She made a series of concerning statements, where she

acknowledged, among other things, that the observed treatment of Baby Y.H. on video was too rough and that her treatment of the 2023 victim babies was like the care that she provided to the 2024 infants.

During this custodial interview, Strotman also made statements that provided probable cause for the seizure and subsequent search of her cell phone. A review of her cell phone communications was concerning. The messages she sent in 2024 indicated her use of increasing doses of Xanax. Strotman texted she knew there were concerns about her treatment of the NICU infants. Most alarming, during one of the time periods where she can be seen on video mistreating Baby Y.H., she is engaged in a text message dispute with her boyfriend.

The Virginia Department of Health ("VDH") became involved in this investigation, as well. In September 2023, HDH self-reported to VDH, which led to an investigation being conducted by VDH. The results of that investigation in 2023 showed, among other issues, that HDH was not appropriately documenting who was conducting heel stick blood draws from individual babies in HDH's NICU. As a result, HDH was required to complete a Plan of Correction. Compliance was achieved with the 2023 Plan of Correction in May of 2024. VDH was called out again to investigate after the incidents that led to the 2024 Joint Investigation.

In December 2024, when VDH became aware of the injuries that sparked the 2024 Joint Investigation, Karen Shelton, MD, the Commissioner of the Virginia Department of Health was alerted. Based on the findings outlined in the 2024 Joint Investigation and VDH's own investigation, a second plan of correction was created to protect patient safety. This plan addressed the significant concerns that VDH had about the safety of patients in the HDH NICU. As part of the plan, HDH agreed to place the NICU on EMS diversion for pre-term labor. It also agreed to suspend new admissions. HDH also agreed to transfer NICU patients who were stable enough to

be transferred and whose parents or guardians consented to the transfer. HDH also agreed to conduct full skeletal surveys, at HDH's expense, of any NICU infant at parental request. HDH also agreed it would employ pediatric radiologists to scan NICU infants instead of just general radiologists, provide re-education about safe handling of NICU infants, conduct background checks for all physicians working in the NICU, and removal of the black boxes that had been placed over the video screens.

As part of the agreement reached between HDH and VDH to manage this emergent situation, an on-site review of the NICU was conducted by the parent company for HDH, HCA Healthcare. This review found that HDH was basically compliant with appropriate protocols, although they did suggest minor reviews of nursing education for basic patient care. The parent company reviewers also seemed focused on "brittle bone" diseases when the report was made back to VDH. It is notable that these reviewers were conducting their review on January 8, 2025, six (6) days after Strotman was in custody for behavior that had been universally agreed to be concerning for abuse.

HDH was incentivized to cooperate with VDH because Dr. Shelton had the authority to close HDH if she felt that patient safety could not be reasonably assured. Moreover, HDH's NICU license was set to expire on December 31, 2024 and could not be renewed without the consent of VDH.

Dr. Shelton, who testified in front of the Special Grand Jury, offered more insight into VDH's actions and responses in both 2023 and 2024. When the original cluster of 2023 victims was identified, Dr. Shelton was not made aware of the situation. Dr. Shelton became aware of the injuries for the first time in November 2024 when she was informed of the injury to baby Y.H. She was then informed when baby L. M.-B.'s injuries were identified on December 17, 2024.

Dr. Shelton was gravely concerned about the pattern and clusters of injuries at the HDH NICU. Trained as an obstetrician, Dr. Shelton was keenly aware that unexplained fractures in non-mobile neonates are pathognomonic for child abuse. As Dr. Shelton put it, the diffuse injuries to Baby L. M.-B. discovered on December 17, 2024 were the "final straw" for her decision making with respect to requiring HDH to enter into an agreement with VDH. She wanted to keep the infants in the NICU safe, and she was forced to balance this desire for safety against the fact that closing the NICU, which had a census of 31 infants, some of whom were acutely ill, could risk patient safety, as well.

For this reason, she commenced negotiations with Ryan Jensen, the CEO of HDH and his boss. It was obvious to Dr. Shelton that HDH's leadership team believed ~~that~~ the injuries were the result of metabolic bone disease. As the conversations about what to do about the HDH NICU unfolded, the single rib fracture to H.W. was discovered on December 24, 2024. One of the limitations that Dr. Shelton was forced to confront was that its authority to suspend or revoke a license is limited and must go through an Administrative Process Act. Additionally, Dr. Shelton did not have the authority to close HDH's NICU only. If she wanted to close the NICU, she had to close the entire facility, which she knew could have massive implications for population health.

Dr. Shelton did not share the opinion of HDH leadership that these injuries were accidental, especially as the investigation unfolded and she saw the videos of Strotman handling these infants. It is Dr. Shelton's opinion, to a reasonable degree of medical certainty, that the injuries observed on the 2024 victim infants are not accidental but were the result of inflicted injury. She believes that the 2024 victim children may have been at risk for metabolic bone disease, which may have made them more susceptible to bone breaks, but she also believes that there are safe handling techniques that prevent breaks.

It was with all these considerations that HDH and VDH, led by Dr. Shelton, were able to successfully negotiate a plan forward for the HDH NICU at the end of December 2024. Dr. Shelton testified in detail about the final contours of the agreement: it required an observer program so that no caregiver was ever alone in a baby's room. It required parent education regarding the situation, and VDH also insisted that the family of every NICU baby be offered, at HDH expense, a skeletal survey. There were other important features in this negotiated plan, including a review of the adequacy of the training program around child abuse and reporting requirements, even though there was no delay in reporting in 2024. VDH also required background checks for all physicians, as well as a separate study of the nutrition program in place in the NICU, which was found to be appropriate. VDH also compelled the removal of the black boxes on the in-room video recordings. Despite their willingness to comply with VDH's requirements, Dr. Shelton believes that HDH's insistence that the fractures were the result of metabolic bone disease was unreasonable, especially once the video evidence of Strotman's conduct emerged.

By January 31, 2025, HDH had drafted and presented its proposed "Quality and Reopening Plan" for the NICU. Representatives from VDH were invited to review the plan, which identified 4 areas for improvement: clinical, neonatology, radiology, and nutrition. It is notable that HDH, as late as January 31, 2025, continued to advance the theory that these injuries had occurred because of metabolic bone disease. VDH investigators were concerned that HDH continued to discuss the possibility of accidental fractures related to incidental care as being the potential source of injury for the 2023 and 2024 victim children, especially because criminal proceedings against Strotman was well underway at this point.

The agreement that HDH and VDH agreed to remained in place in some form until June 30, 2025. The remaining issue for Dr. Shelton to address was the renewal of HDH's license

considering the grave concerns regarding the NICU.

The eventual decision was made to renew HDH's license with a conditional license on the NICU. The original condition on the license was through April 1, 2025 with the understanding that HDH had to reapply to operate a NICU by April 1, 2025. Dr. Shelton also commented that VDH wanted to keep admissions to the NICU suspended until all the videos had been fully viewed to make sure that there were no additional people of concern or other situations of concern. A complete review of all the video revealed another victim of concerning behavior at Strotman's hands, but fortunately, a scan showed the child did not have any broken bones. Dr. Shelton felt that reopening HDH to admissions was appropriate by February 2025 because Strotman had been identified as the perpetrator of the non-accidental trauma and was no longer employed at HDH. Additionally, HDH was fully compliant and committed to quality and safety for the babies starting in December of 2024.

Despite what Dr. Shelton described as a crisis, she nevertheless believes that once the HDH team saw the videos of Strotman, they acted appropriately. Specifically, HDH quickly terminated Strotman. VDH was frustrated in its attempt to determine how Strotman had been permitted to return to the NICU because HDH would not provide detailed information about Strotman's employment history, citing confidentiality concerns.

Dr. Shelton was also asked to testify about the results of an April 11, 2025 Centers for Medicare & Medicaid Services ("CMS") report. This investigation that underpinned this report was initiated because of the unexplained fractures from November 2024 but it wound up revealing other problems inside of the NICU. The report focused on several areas. First, it pointed out that there was a discrepancy in a radiology report. Second, it found that HDH failed to obtain consent before it administered a vaccine to a NICU infant. Third, the report commented that these

unexplained fractures took place inside the NICU and that HDH had not done enough to prevent this from happening. This report also documented concerns about nursing care and oversight related to infection prevention and a bacterial MRSA outbreak.

VDH was not the only Commonwealth of Virginia entity who investigated the 2023 and 2024. Once Strotman was identified as the perpetrator, the Department of Health Professions ("DHP") also had an interest in conducting an investigation to see if Strotman should retain her license to practice nursing. Sharon Negron is the senior investigator who was assigned to investigate the matter. During her testimony, she was able to outline Strotman's short nursing career which began at HDH in 2019 and ended when she was fired on January 2, 2025. Ms. Negron commented that HDH was supposed to notify DHP whenever an employee has an "adverse employment action." Ms. Negron pointed out that if HDH had notified them in 2023 when HDH placed Strotman on administrative leave, DHP would have conducted an investigation of Strotman then.

Ms. Negron found that by 2024, Strotman was diagnosed with a major depressive disorder and generalized anxiety disorder. She had valid prescriptions for Aprazolam[6] and an SSRI antidepressant. She also had a diagnosis of fibromyalgia and had a prescription for THC for its treatment. There was evidence that Strotman was prescribed larger and larger doses of aprazolam. There was no evidence that Strotman ever disclosed these diagnoses or her prescription medication use to anyone in a position of authority at HDH. Ms. Negron uncovered that Strotman had a history of brief hospitalization for mental health illness as a teenager, something that Strotman failed to disclose during her onboarding process at HDH. Ms. Negron also reviewed HDH policies regarding use of medication that could impair work performance or employee health and testified that HDH relies primarily on employee self-reporting. Strotman never reported her use of

[6] This is the generic for Xanax.

alprazolam or THC.

Ms. Negron also interviewed the former Director of the NICU at HDH and the current NICU Director of HDH and showed them the videos of Strotman handling the victim children from 2024. After reviewing the videos, not even one thought that Strotman was safe to practice nursing. In fact, Strotman herself was the only person who said she was still safe to practice nursing.

Dr. Foster, the Child Abuse pediatrician who was consulted in both the 2023 and 2024 CPS and SVU investigations was retained by the Special Grand Jury to provide testimony and opinions related to the injury patterns seen on the 2023 victims. In her capacity as expert, she was provided the related records for each of the 2023 victim children. She conducted a comprehensive review of each of these victim babies' records as she formed her opinions. Dr. Foster was also shown a video of Strotman handling the first of the 2024 victims. Dr. Foster testified HDH's belief that the injuries occurred spontaneously because of fragile bone syndrome in these four 2023 victim children is wrong. Two of the four 2023 did not have any evidence of any type of osteopenia of prematurity, and the other two just had slightly increased risk factors, but nothing that established a conclusive diagnosis. Dr. Foster was not prepared to say to a reasonable degree of medical certainty that she could exclude osteopenia of prematurity as a causative factor of the small preterm infants' fractures, but she also said that these fractures did not align with characteristic findings that she would expect to see.

As Dr. Foster reached her opinions, she relied heavily on the Children's Hospital of Philadelphia 2021 retrospective study of fractures in the context of the NICU setting (the "CHoP Study"). She pointed out the markers and risk factors for fractures in the context of the NICU. She first stated that the children who got the fractures in the CHoP Study all had very high alkaline

phosphatase levels and very low phosphorus levels. She also noted most of the children who got fractures were on a ventilator, had received diuretics, and were TPN. She also highlighted the rarity of fractures in the setting of the NICU and the reason the fractures are so rare. Most of these children are not moving on their own or being moved in a way that would cause enough force for a fracture.

Dr. Foster also rejected the hospital's assertion that osteopenia of prematurity, itself, causes spontaneous fractures. She offered as evidence that none of the 2023 victims bore out over time to have anything else underlying that would have caused osteopenia of prematurity. Additionally, none of them have had subsequent fractures, and none of them have had a diagnosis of osteogenesis imperfecta made in terms of them having some genetic kind of underlying disorder. Additionally, none of these children had rickets. In short, there was no evidence that these four 2023 victim infants were unusually susceptible to these injuries.

When asked about HDH's theory that the injuries were the result of accidental mishandling, Dr. Foster commented that if she removed the smallest of the 2023 infants (the one born at 23 weeks), she could say to a reasonable degree of medical certainty that the fractures of the remaining infants couldn't have happened without severe forces being applied and the intent to injure. With respect to that smallest infant, it was her opinion was the number of fractures and the constellation of findings were inconsistent with the way that we normally see cases of osteopenia of prematurity present in terms of lower numbers of fractures. Putting aside this one very small child, about whom Dr. Foster was still concerned, for the remaining three children, there was no offered history that made sense for accidental injury.

Dr. Foster discussed the mechanisms of injuries in the 2023 victim children, which she opined could have been caused by more than one type of mechanism of force. She described the

force required to break the rib as being a circumferential squeezing that would have to be done by an adult. Dr. Foster was also willing to comment on the mechanism and type of force for the transverse fracture on the left radius that was observed: she described the range of motion outside of the normal range of the joint, and she described that the force would have to be intentional. She also said that it was a mechanism and force that a trained NICU nurse would have immediately recognized as not meeting the accepted standard of nursing care. With respect to the observed injuries in the distal femur, Dr. Foster commented that the range of motion and the force would be abnormal, so much so that a lay person would recognize it as injurious to an infant and that the infant would respond in pain when these bones are fractured. It would not have been possible to cause these injuries during normal NICU diapering procedures,

In discussing the observed bucket fracture, Dr. Foster commented that there would have had to be a substantial amount of force and torque to cause the observed injury. She stated that the behavior would have been immediately recognizable as inappropriate care of a NICU infant, and it would have been behavior that any NICU nurse would have been trained to avoid. This injury could not have been accidental, and the baby would have responded with a pain response.

In discussing the observed buckle fractures of the radius and ulna, Dr. Foster stated that the perpetrator would have had to push in and put compression force on the arm for the radius to buckle the way it did. The buckle fracture could have happened if the child was on a flat surface and was being pressed forcefully down into the mattress of the isolette. This is the sort of injury that would be expected if a full-sized adult transferred all her weight onto one of the extremities. Dr. Foster said that the mechanism that Strotman was observed using on Baby Y.H. could have caused this observed injury and is discussed further in later sections of this report.

Dr. Foster said that she thought that the records from Strotman's onboarding were

appropriate and commented on the propriety of the NICU fragile bone protocol. She also commented that Strotman had relatively less education, training and experience for the position than nurses who were employed by VCU. That being said, there was nothing in the record that suggested that Strotman was improperly trained.

Dr. Foster then testified about the injuries to 2024 Joint Investigation Baby No. 1, Y.H. She pointed out that this was a child who did not have risk factors for osteopenia of prematurity and the time that his fractures were discovered. The attempt by the physicians at HDH to make a provisional diagnosis of osteopenia of prematurity was flawed because his labs did not support such a finding. Dr. Foster opined that another potential cause of the injury was trauma that was non-accidental in nature and forceful, especially after she was able to eliminate other potential metabolic bone diseases as the potential cause. Even if he had osteopenia of prematurity, that would not have accounted for the constellation of injuries that this child suffered. These injuries were very concerning for non-accidental trauma.

Dr. Foster was asked to comment on a single video of Strotman with 2024 Baby No. 1. After review, she said that the interaction was "not appropriate" because Strotman was hyperextending the legs all the way up and was pushing her weight into them. Dr. Foster commented that she had "never seen" anyone extend the legs up over the infant in the fashion that Strotman did it. Dr. Foster also commented that Strotman's actions caused the heart rate and the breathing rate to be elevated which was displayed on the monitors, because the child was in pain. The child was also crying, fretful, and fussy. Dr. Foster also commented that Strotman was extending the child's limbs beyond the range of motion of the joint. She also commented that his eyes became large, probably because of the pain response.

IV. Summary of the Findings and Recommendations of the Special Grand Jury

After listening to all the testimony that was received, the Special Grand Jury met extensively and made the following findings. The Special Grand Jury's findings are supported by the testimonial evidence and exhibits that were offered and received during its proceedings. Each of these findings is addressed in greater detail in the Discussion section.

First and foremost, the Special Grand Jury finds probable cause exists for the charges that it returned against Strotman involving the four 2023 Joint Investigation victims. The Special Grand Jury took the standard of probable cause seriously and was thoughtful in its consideration of the evidence that it was presented. In making this finding, the Special Grand Jurors gave weight to the testimonial evidence that was provided to it regarding the events that were investigated related to the 2023 Joint Investigation. The Special Grand Jury was meticulous in its process. It first carefully considered the evidence that existed at the conclusion of the 2023 Joint Investigation. Then, it considered the evidence that was collected during the 2024 Joint Investigation, especially the statements offered by Strotman herself about the videos of the 2024 victim child and the statements that she made to the investigator from DHP. The Special Grand Jury also considered and relied upon the testimony offered by Drs. Shelton and Foster.

The Special Grand Jury, who was tasked with evaluating all criminal conduct that took place at HDH, also made the finding that HDH's deliberate delay in reporting to CPS in 2023 materially harmed the 2023 Joint Investigation and impeded the 2023 Joint Investigators from identifying Strotman as their sole suspect. Similarly, the failure to report to DHP that Strotman had been removed from the nursing schedule in 2023 materially harmed the 2023 Joint Investigation and delayed the 2024 Joint Investigation. Additionally, HDH's articulated belief through both the 2023 and 2024 Joint Investigations that the observed injuries to the victim infants was the result of metabolic bone disease or "spontaneous fractures" was unreasonable and contrary

to the state of the medicine.

The Special Grand Jury also had grave concerns about HDH's record-keeping practices. Documentation in the NICU in 2023 of both employees working with and procedures performed on NICU infants was poor and materially harmed the 2023 Joint Investigation. This careless approach was reflected in many of the practices employed by HDH including HDH's decision to return Strotman to work in the NICU without confirming she was drug-free and psychologically stable enough to return when there were other positions available that involved interaction with less vulnerable patients.

Similarly, the Special Grand Jury found that HDH's failure to monitor patient care performed by nurses in 2024, especially after Strotman was returned to work, was inexcusable because the videos were readily available. Further, HDH's decision to block out sections of video was a poor one. Additionally, the Special Grand Jury made the specific finding that, even after the 2023 Joint Investigations, HDH was cavalier about NICU patient safety. Moreover, HDH's standards for nurses working in the NICU in 2023 were not high enough. Finally, the Special Grand Jury also found that the cloak of secrecy that HDH threw over its internal investigations and documents with the assertion of attorney-client privilege was problematic because it left sections of both the 2023 and 2024 Joint Investigations unexamined.

In response to these findings, the Special Grand Jury made recommendations for HDH, DSS, the Commonwealth's Attorney's Office, and the Virginia General Assembly. First, the Special Grand Jury recommends that the mandatory CPS reporting law of the Commonwealth be posted on HDH's website, in every patient room, included in NICU onboarding materials, and reviewed with every individual working with NICU children at HDH. Second, the Special Grand Jury recommends that HDH employ an ombudsman to assist families through the CPS reporting

process. Third, contemporaneous video reviews should be conducted of patient care in the NICU on a quarterly basis to confirm patient safety. Fourth, quarterly in-services related to child safety standard of practice should be conducted. Fifth, a mandatory annual in-service on HDH's fragile bone protocol that includes the latest research should be conducted at HDH. HDH should retain a board-certified child abuse pediatrician on its staff and every CPS referral that is made should be reviewed by that physician. Sixth, HDH should enhance its requirements for working in the NICU and establish minimum requirements of at least a Bachelor's of Science in Nursing and five (5) years of nursing experience. Seventh, HDH should conduct a study to confirm that its choice of private rooms is the safest choice for these vulnerable infants. Eighth, HDH should require mandatory prescription drug checks and random drug screens for employees assigned to the NICU. Ninth, the onboarding period for NICU nurses should be extended. Finally, any time a NICU nurse is removed from the schedule or placed on administrative leave, it should be considered an "adverse employment action" and DHP should be informed.

The Special Grand Jury also had recommendations for CPS to improve its response in this type of situation. Specifically, the Special Grand Jury recommended that CPS implement a system for reviewing compliance with safety plans when they involve an entity that provides health care. Additionally, the Special Grand Jury recommends that CPS investigators and supervisors should be empowered with appropriate knowledge and information to appropriately review and if necessary, challenge medical opinions that are presented to them. Moreover, the Special Grand Jury also suggests that CPS create a database of partner agencies and contacts that handle licensure for health care entities so that communication between these partner agencies is more seamless. This recommendation goes hand-in-hand with another recommendation, which is that there be coordination and execution of meetings with investigators from VDH and DHP to facilitate future

coordination of investigations should it ever become necessary again.

CPS was not the only governmental agency to receive recommendations from the Special Grand Jury. The Special Grand Jury also made recommendations to the Commonwealth's Attorney's Office. First, it recommends that the office coordinate and execute informational sessions with lawyers from coordinated entities like VDH and DHP so that there is better communication and exchange of information during periods of investigation. Moreover, it is recommended that the Commonwealth's Attorney's Office offer professional development opportunities for aligned stakeholders.

The Special Grand Jury also offered recommendations to Virginia's General Assembly. The Special Grand Jury recommends that the General Assembly enact legislation that expands the power of VDH so that it can suspend the license of an individual unit inside of the hospital, not just the whole hospital. The Special Grand Jury also recommends that VDH and CPS be given the power to fine hospitals that are found to be out of compliance with safety plans implemented as the result of articulated concerns for abuse or neglect.

Moreover, the Special Grand Jury recommends a significant amendment to §63.2-1509 to make failure-to-report crimes involving physical abuse of a minor a jailable offense. Additionally, the Special Grand Jury recommends that there be an additional offense created for health care providers who commit abuse crimes against children in their care.

Finally, the Special Grand Jury recommends that legislation be created that prohibits any health care entity from designating documents or investigation as protected by attorney-client privilege in a child abuse or neglect case.

V. Discussion of the Summary of the Findings of the Special Grand Jury

a. The Special Grand Jury Believes that Probable Cause Existed for the Charges Against Strotman Involving All of the Victims of the 2023 Joint Investigation and Returned Indictments Against Her.

On May 2, 2025, the Special Grand Jury returned indictments against Strotman for all four victims, Z.M., T.M., M.L., and N.H. The Special Grand Jury found probable cause for one count of Class 4 Felony Child Abuse and one count of Malicious Wounding for each of the four victims. The Special Grand Jury made these findings for six reasons. First, they were compelled by the Windows of Opportunity document prepared by Dr. Reece sometime before CPS was notified in September 2023[7], which placed Strotman as the only nurse caregiver with access to all four children during the time of injury. Second, the testimony offered regarding the non-accidental nature of these observed injuries of HDH's treating physicians Drs. Gardiner, Kuta, and Carra was compelling, as was the testimony of Karen Shelton, the Commissioner of the Virginia Department of Health. Third, they accepted Dr. Foster's testimony and rejected HDH's assertions that these breaks were "spontaneous" and were the result of the 2023 victim infants all having metabolic bone disease. Fourth, Dr. Foster pointed out that the constellation of injuries observed to the first victim on film in 2024 was remarkably similar to the injuries observed to the cluster of 2023 victims. Fifth, every professional who reviewed the videos of the care Strotman provided to the 2024 Joint Investigation was appropriately concerned and not even one believed that it met the appropriate standard of nursing care for NICU children. In fact, after investigation, Strotman was the only person who was willing to say that the care was competent and that she was safe to practice nursing. Sixth, Strotman's statements about the care that she provided to the 2024 and 2024 Joint Investigation victims offered concessions that she was too rough.

[7] CPS Investigator Wilson was unsure of the date that the Windows of Opportunity document was generated: it was provided the 2023 Joint Investigators in early October 2023.

i. The Windows of Opportunity document prepared by Dr. Reece established Strotman as the only nurse caregiver with access to all for 2023 victim children during the time that the injuries took place.

In deciding whether probable cause to indict existed, the Special Grand Jury relied heavily on the evidence offered by the 2023 Joint Investigators regarding Dr. Reece's concerns and his creation of the so-called Windows of Opportunity document. Dr. Reece is an experienced and well-regarded radiologist in the greater Richmond area who has been in practice since 1988. Dr. Foster, the expert retained by the Special Grand Jury commented about Dr. Reece that she trusts his reads of films of children who are transferred to VCU from other facilities implicitly.

Dr. Reece was the first radiologist to express concern that the observed injuries to the 2023 victim children were inconsistent with accidental injury and consistent with and concerning for non-accidental trauma, findings that were documented in the medical records. Dr. Reece was candid with the 2023 Joint Investigators: when he saw this cluster of injuries in 2023, he had never seen anything like it in his career. He told the 2023 Joint Investigators that NICU infants should not have injuries like the fractures he observed because they are not mobile. Dr. Reece elevated his concern to the Chief Medical Officer of HDH, Dr. Singh, and based on his concern, Dr. Reece created his Windows of Opportunity document, a document that became a central piece of evidence. Dr. Reece rejected offered theories that these observed fractures were caused accidentally. He did not think that they were caused by nurses providing routine care, like starting IV lines or swaddling infants. Dr. Reece did what he could to bring his concerns to the attention of HDH leadership. He was asked to participate in a meeting about the cluster of observed injuries on September 11, 2023, and offering his opinion, he was not consulted at any time after that.

After Dr. Reece's document was prepared, administrators at HDH quickly established that Strotman was a caregiver in common for all four 2023 victim babies. This was confirmed by an analysis of the schedules that was conducted by CPS investigator Sarah Wilson, who also testified

and whose testimony was also found to be credible. Based on the Windows of Opportunity document, HDH placed Strotman on administrative leave in 2023 before CPS was ever notified of any of these children's injuries.

It is notable that Dr. Foster was consulted in October 2023 to participate in the 2023 Joint Investigation and when she did, Dr. Foster suggested that the Windows of Opportunity timeframe offered by Dr. Reece could be slightly larger than Dr. Reece believed that it was, but even if Dr. Foster was correct, Strotman was nevertheless still one of the key caretakers for all the victim children during 2023.

ii. The testimony regarding the non-accidental nature of these observed injuries of HDH's treating physicians Drs. Gardiner, Kuta, and Carra was compelling, as was the testimony of Karen Shelton, the Commissioner of the Virginia Department of Health.

Drs. Gardiner, Kuta, and Carra, all board-certified radiologists, all saw the same injuries that Dr. Reece did, and in 2023 they expressed concern about non-accidental trauma to different degrees. Specifically, Dr. Gardiner told the 2023 Joint Investigators that the fractures were highly suspicious for non-accidental trauma. Dr. Gardiner had never seen anything like the cluster of injuries that he saw in 2023 in his career. He commented that whenever there is an immobile infant who has a metaphyseal corner fracture, that is pathognomonic for inflicted injury in the absence of a history that explains the shearing injury. Dr. Gardiner also offered an important point that HDH administrators ignored: it was possible that less force would cause this type of injury to NICU babies, but it is also possible to care for NICU babies who are at risk for metabolic bone disease in a manner where this type of injury never happens.

Dr. Kuta offered the 2023 Joint Investigators similar concerns: he had never seen bucket fractures on children who had not been out of the hospital. He was not inexperienced with fractures that were concerning for non-accidental trauma, but never in the context of NICU infants. He had

also never seen a cluster of injuries like the ones that he observed in 2023.

Dr. Carra's 2023 involvement with these matters commenced when Dr. Balint consulted with him regarding the baby who had a fracture of the distal ulna and radius. Dr. Carra reviewed the films and because the child was non-mobile, Dr. Carra believed that the injury was traumatic and likely inflicted in nature. This is what he told the 2023 Joint Investigators and what he communicated to Dr. Balint.

Dr. Shelton, the Commissioner of Health for the Virginia Department of Health, also described her reaction to learning about the 2023 Joint Investigation. She said that she was on "high alert" because it is generally true that unexplained fractures in non-mobile neonates is concerning for child abuse. Dr. Shelton was also concerned because, as she put it, it is absolutely possible to treat a child with metabolic bone disease and never have that child have a single fracture.

Despite these three opinions from three reviewing radiologists in 2023, HDH continued to advance a theory of accidental injury. This became an even more untenable position after October 2023, when Dr. Foster was consulted as part of the 2023 Joint Investigation and she opined that the injuries were highly concerning for non-accidental trauma in a meeting where HDH, by counsel, was present. On some level, HDH must have had some level of concern, because it was HDH who placed Strotman out of work before they notified CPS. Dr. Shelton commented that even as late as December 2024, when there were two documented clusters of injury, it remained the articulated position of HDH that all these fractures were the result of metabolic bone disease[8]

[8] The members of the Special Grand Jury were not unanimous in their belief that HDH cares more about the brittle bone narrative than the care of their patients. While some members of the Special Grand Jury believed this, others believed that the references to brittle bone disease or no comment were appropriate.

Individual members of the Special Grand Jury commented that HDH was in a difficult situation: it could not accuse anyone without sufficient evidence and that later, HDH had to protect itself from litigation until it was able to see the entire picture. As a Special Grand Juror commented, "Henrico Doctors' Hospital's mission is to provide exceptional

and not inflicted injury. To date, HDH never offered, at least not to Dr. Shelton, what the basis of its opinion that all the fractures were the result of metabolic bone disease was.

iii. The Special Grand Jurors believed Dr. Foster's analysis of the bone health of the 2023 babies and the force that it would have taken to cause the observed injuries and rejected HDH's assertions that these breaks were "spontaneous" and were the result of the 2023 victim infants all having metabolic bone disease.

Dr. Foster's testimony was compelling and destroyed any notion that the fractures were spontaneous or could have been caused during care that met the accepted standards of NICU nursing care.

Dr. Foster articulated the risk factors for metabolic bone disease: infants who are born before 28 weeks, who weigh less than 1500 grams at birth, who are on IV nutrition instead of the gut, who have been on a course of steroids or loop diuretics, are all at greater risk for metabolic bone disease than those who do not have those features. Additionally, neuromuscular disorders increase the risk of metabolic bone disease. Metabolic bone disease is typically diagnosed through a review of lab work. Infants with metabolic bone disease have very high alkaline phosphatase levels and very low phosphorus levels. Metabolic bone disease is important in the context of the 2023 victims because the bones of a child with metabolic bone disease will break more easily than a child who does not have metabolic disease. In 2023, HDH espoused the theory that the reason for these observed fractures was that all the affected children had some varying degree of metabolic disease. This is a flawed theory because there are appropriate handling methods for NICU infants that minimize risk of accidental injury, but Dr. Foster thinks that these babies were the victims of inflicted trauma, not children with metabolic bone disease who were handled appropriately and got fractures anyway. Dr. Foster pointed out that in a 2021 study from Children's Hospital of

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care for its patients, saving lives and preventing patients and visitors from being injured or becoming ill due to their internal practices." This Special Grand Juror's family has received what was described as "exceptional care" from the professionals at HDH.

Philadelphia (the "CHoP Study"), a retrospective 5-year study showed that only about one percent of the very sickest NICU babies ever had a single fracture.

Dr. Foster's review of the records of the four children who were the 2023 Joint Investigation victims dispels the theory that metabolic bone disease is to blame for the observed injuries. Two of the four 2023 victims did not have it at all, and the other two had increased risk factors but their labs never rose high enough to constitute a formal diagnosis of metabolic bone disease. There was no evidence that these four children should have been unusually susceptible to these injuries, and even if they were, based on the research, any accidental injury would have likely been confined to a single fracture.

Dr. Foster discussed the mechanisms of injury that she would expect to see for the 2023 victim children. As she related, there would have been several types of force, including circumferential rib squeezing and pressure with a range of motion of joints outside of the normal range of the joint. Dr. Foster discussed the fact that the amount of force would have to be intentional. She also said that a trained NICU nurse would have immediately recognized it as not meeting the accepted standard of nursing care. She commented that the force would be abnormal, so much so that the lay person would recognize it as injurious to an infant and that the infant would have responded in pain to this level of force. In discussing the amount of pressure required to cause the observed buckle fractures, the amount of force is the amount that would be expected if a full-sized adult transferred all her weight onto one of the extremities.

Dr. Foster's opinions and conclusions were borne out in the evaluation of the videoed treatment of the injured victims of the 2024 Joint Investigations. The Special Grand Jurors witnessed with their own eyes Strotman executing just the maneuvers that Dr. Foster said would cause the observed injuries to the 2023 infants. She squeezes a 2024 victim child's ribcage, she

puts pressure on joints outside of the range of motion, and she transfers all her weight onto an infant. In fact, in one of the videos observed by the Special Grand Jurors, the entire mattress on which the victim child is resting moves up and towards her because she is putting so much pressure on the victim child. Importantly, the victim children react with the anticipated pain response. Their respiration and pulse increase, eyes widen, and they become fretful and fussy. In short, the victims of the 2024 assaults that are captured on video act just the way that Dr. Foster predicted they would because the pain to these children is real and acute. Moreover, there was not a single medical professional, save Strotman herself, who said that the observed behavior by Strotman in 2024 met the accepted standards for nursing care. To the contrary, once Strotman was removed from the NICU in 2023, there were no more unexplained fractures until she was returned to the NICU in 2024. Since she was terminated, there have been no more unexplained fractures. The Special Grand Jurors do not believe that it was a mere coincidence that the 2023 fractures occurred when Strotman had care of those infants, that no fractures occurred again until she was returned to work in 2024, and then there have been no more unexplained fractures. That defies common sense and reason.

iv. Dr. Foster pointed out that the constellation of injuries observed to the victim on film in 2024, Baby No. 1, was remarkably similar to the injuries observed to the cluster of 2023 victims.

The Special Grand Jurors had the benefit of being able to examine the 2023 Joint Investigation and its victims in the context of the larger context of Strotman's continuing offenses. The medical records for each child from both 2024 and 2023 are instructive: they show a pattern of injuries that are simultaneously similar and highly pathognomonic for child abuse. For the most part, the bones broken were limbs, although several of the children had rib involvement, as well. The two primary types of fractures that were observed in 2023, and then again in 2024, are the so-

called bucket or bucket handle fractures and the buckle fractures. As noted above, Dr. Foster was able to articulate the very specific force and mechanism that it takes to cause these two types of injury.

The Special Grand Jury found the similarities of injuries significant and persuasive as classic *modus operandi* evidence. The video evidence was additionally persuasive to confirm that Strotman was the person who inflicted injury on the children in 2023 as the observed 2024 videos showed her engaged in just the type of behavior that Dr. Foster said would cause the observed injuries, also with the pain response demonstrated by 2024 Baby No. 1. This evidence was also persuasive because Strotman said she treated the babies in 2023 the same way that she treated them in 2024.

v. Every professional who reviewed the videos of the care Strotman provided to the 2024 Joint Investigation was appropriately concerned and not one believed that it met the appropriate standard of nursing care for NICU children. In fact, after investigation, Strotman was the only person who was willing to say that the care was competent and that she was safe to practice nursing.

One of the challenges of this Special Grand Jury's inquiry was HDH's continued reliance on the position that the injuries spontaneously occurred, despite overwhelming evidence to the contrary offered by multiple experts, some of whom practice at HDH. In fact, even during the Board of Nursing investigation conducted by Sharon Negron, Ryan Jensen, the CEO of HDH, still espoused the obviously incorrect theory that micro-preemies have "spontaneous fractures." This rejection of the state of the medicine, particularly the 2021 CHoP Study that Dr. Foster reviewed and on which she relied that demonstrates that fractures happen in the context of clinical procedures in only about 1% of the very sickest babies, defies common sense and prudence and suggests that Jensen and HDH sought to prioritize institutional protection over protection of vulnerable NICU infants.

It is important to understand why HDH approached this situation with such obvious bias in the face of overwhelming evidence. Dr. Shelton provided what is probably the most accurate assessment of why HDH continued to use its flawed approach, stating, "I think the natural inclination is that you don't want to think that one of your employees, or a visitor, or something is wrong with your hospital, that someone is perpetrating non-accidental trauma." Because the Special Grand Jury had the benefit of being able to retrospectively review the entire life cycle of this matter, the Special Grand Jury also believes that some of the bias may have been the parent corporation's attempt to shield itself from civil liability. That argument is undercut somewhat by the fact that HDH inexplicably returned Strotman to work in the exactly the same role in 2024 that she had been removed from in 2023. HDH's loyalty to Strotman is certainly the greatest miscalculation in this event, and one that had tragic consequences for four families in 2024. The suffering of four babies in 2024 could been avoided by reassigning Strotman to a unit with adult patients who had lower acuities; patients who could have voiced a complaint if they were being harmed by Strotman.

Putting that aside, the 2024 Joint Investigators were fortunate to have video recording of each patient room, although it also bears repeating that HDH's unilateral decision to block out areas in the room for nursing privacy[9] ignores the more basic concern about patient safety in the context of unexplained fractures in the NICU, every professional who reviewed the videos of the care Strotman provided to the 2024 Joint Investigation was appropriately concerned and not a single one believed that it met the appropriate standard of nursing care for NICU children. In fact, the only person who has reviewed the videos and espoused the position that the observed behavior is acceptable is Strotman herself.

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[9] The Special Grand Jury notes that breastfeeding rates in the NICU are lower than in general populations and points out that HDH could have implemented other strategies to protect the privacy of nursing mothers that also preserved the video footage that was irretrievably lost by placing the black boxes on the video equipment.

Sharon Negron's testimony provided an accurate snapshot of how the internal HDH employees grade Strotman's care. Sarah Scheer, Strotman's supervisor in the NICU reviewed selected clips of Strotman providing care to 2024 victim children and made statements such as "everything she does in the video is concerning." She called the 2024 videos "shocking." The term "shocking" was used by more than one HDH reviewer. Ryan Jensen called the videos "unexplainable." Lisa James, the NICU nurse trainer for HDH, commented that Strotman's skills were both very poor and very low. Ms. James also wondered out loud where Strotman had learned the inappropriate maneuvers that she was captured performing on the video. Jennifer Young, the VP of Quality at HDH, after expressing her dismay about Strotman's performance, commented that one of most concerning features of Strotman's performance was how differently she behaved when she was alone in a room with an infant and when she was in a room with a colleague. Ms. Young commented, correctly, that videos exist where Strotman can provide safe and appropriate care. It is worth pointing out that this duality of care is probably how Strotman survived at HDH as long as she did. Former supervisor Mandy Winton stated that she did not believe that Strotman would ever have harmed any of the NICU infants. Other colleagues and supervisors who described Strotman as cheerful and a "breath of fresh air" in the NICU. In fact, Strotman who had only been disciplined at work once for tardiness, had all average or slightly above average evaluations, and was recommended for positions like charge nurse and encouraged to seek her bachelor's degree in nursing.

Professionals outside of HDH who reviewed the videos concurred with what HDH's staff told Sharon Negron. Dr. Shelton, who spent her clinical practice years as an OB/GYN and thus understands appropriate standard of care for NICU infants, did not believe that what she observed on the video comports with appropriate standards of nursing care. Dr. Foster, who was qualified

as an expert and commented on a single video offered to her showing Strotman providing care to 2024 victim baby No. 1 commented that the observed behavior did not meet the standards for nursing care. Specifically, she stated that Strotman hyperextended the child's legs and pushed her body weight into the legs. Moreover, Dr. Foster stated that she had "never seen" anyone extend a NICU baby's legs up over the infant in the way that Strotman is observed doing it on the video. Dr. Foster pointed out that Strotman was extending the child's limbs beyond the range of motion for the joints. Strotman was also immune to the obvious pain response of the child. The child's heart rate and breathing rate, both good indicators of the pain response, were elevated. During the interaction, the child was also crying, fretful, and fussy and the eyes became large, probably because of the pain response.

Perhaps not surprisingly but certainly strangely, Strotman herself was quite literally the only person who ever said that her nursing skills were acceptable. While she was candid with investigators about what was readily observable about her nursing in 2024 on the evening of her arrest, by the time she met with Ms. Negron, her position had changed entirely. With her lawyer beside her, she made a series of claims that defied logic. After telling Ms. Negron that she was properly trained, she classified her clinical skills as an 8 or 9 of 10 on a 10 point scale, and denied that she needed to improve. Even after viewing the concerning videos of herself, she told Ms. Negron that she was safe to practice nursing and did not believe there was anything she needed to do prepare to return to nursing. No one else who was interviewed by Ms. Negron agreed with Strotman's delusional, after-manufactured self-assessment.

v. Strotman herself told investigators that she was too rough in the videos and that she treated the 2023 victim infants the same way she treated the 2024 infants who could be observed on video.

Obviously, the Special Grand Jury was faced with the challenge that the videos that it had to review were not videos from 2023 but showed concerning behavior from over a year after the

events leading to the 2023 Joint Investigation. As much as everyone involved in the 2023 Joint Investigation wanted video and as obvious as the deficiencies in care from Strotman are in the videos in 2024, the same evidence is not there in 2023.

It was, however, unequivocally established that Strotman was one of the people with documented access to all four victim children in 2023. This information was first established by HDH itself and then confirmed by Sarah Wilson based on the scheduled work shifts and the Windows of Opportunity document first prepared by Dr. Reece. While the timeline was opened somewhat by Dr. Foster's expansion of the Windows of Opportunity, it only opened enough to include one additional nurse.

During her post-arrest, custodial interview on January 2, 2025, Strotman ratified that she was too rough in the videos that she was shown of her with 2024 Baby No. 1. After protracted attempts to minimize and deflect, Strotman eventually conceded that her video recorded 2024 behavior was out-of-bounds. Specifically, she said, "I could see how in that video it seems more force-forceful that it needed to be….I'm not trying to hold anything back. I, um, feel like I could have been more light-handed? Yeah….I feel like it, it can be perceived as a little too rough. Now, like on the video it looks, it looks like I did lean my weight into him. Okay. With his history and the prematurity sort of, but in the moment it didn't feel too rough. A little? Yeah. After seeing the video? Yeah." Strotman agreed that her care for the infants who were the subject of the 2023 Joint Investigation was consistent with the care that she was videorecorded as providing in 2024. In response to Sgt. Fitzer's question in the context of watching the 2024 videos of concern, "So this is what you've been doing with all the babies, is that correct?", Strotman is unequivocal. She says, "Yes. For the past two years. Okay."

The Special Grand Jurors took note of the fact that Strotman appeared to have received

appropriate education that she was ignoring. Repeatedly during her post-Miranda interview, Strotman parroted safe NICU handling practices that she appeared to understand but is witnessed ignoring when caring for NICU infants. She articulates understanding that these babies are "easy for breaks." She knows that these children should not have their legs lifted above their heads. She even seems to understand some of the reasons that underpin this rule. She tells Det. Lynch that keeping the legs low helps prevent intraventricular hemorrhage. Strangely, Strotman has created some techniques that are specifically precluded at HDH. For example, she ratifies the use of "bicycling" the legs to relieve gas pain, stating that "the bicycles are a common way that we try to relieve gas for them." She was never trained to do this.

In her Board of Nursing interview, when she had a lawyer sitting next to her, Strotman confirmed that she had been appropriately trained. Dr. Shelton and Dr. Foster both agreed that the training program for HDH NICU nurses appears to be an appropriate curriculum. As the investigation unfolded in full, Strotman appears to have set aside her training in favor of untested, dangerous self-taught techniques.

Additionally, the Special Grand Jurors gave weight to the discrepancy between the gentle behavior that Strotman displayed when she conducted her reenactment with the reenactment doll and the behavior that she displayed on screen, especially in light of the statements made by HDH's VP of Quality, Jennifer Young, who discussed Strotman's uneven performance as a nurse that was better when she was being watched and worse when she wasn't.

All of this exists inside of the framework of the relative rarity of fractures in the context of the NICU setting. Dr. Reece, HDH's own radiologists, and his colleagues, Dr. Gardiner, Dr. Carra, and Dr. Kuta, had never seen anything like this cluster of injuries that appeared in 2023 shortly after Strotman completed her training and was permitted to provide nursing care alone. Notably,

the other nurse who met the care criteria for the Windows of Opportunity had been a nurse for over 20 years at the HDH NICU and no such incidents had ever taken place. Once Strotman was placed on administrative leave, the unexplained fractures ended. They only began again once she was returned from administrative leave. As CPS witnesses testified, there have not been any concerning unexplained fractures since Strotman was placed back on administrative leave and then fired.

b. The Deliberate Delay in Reporting As Required to Child Protective Services in 2023 Materially Harmed the 2023 Joint Investigation.

The delay of approximately six weeks from the first documented injury on August 5, 2023 to the time that HDH CEO Ryan Jensen and VP of Quality Denise Weisberg was destructive to the 2023 Joint Investigation because it left NICU babies vulnerable to harm that potentially could have been avoided, it deprived the 2023 Joint Investigators of valuable investigative techniques, and this choice demonstrates that HDH prioritized limiting hospital liability at patient safety expense. Moreover, Special Grand Jury believes that the delayed reporting by the CEO of HDH and the VP of Quality shows an attempt to obfuscate instead of requiring immediate disclosure

The first fracture on the first child who was a subject of the 2023 Joint Investigation was documented on August 5, 2023. CPS was not notified until the end of September, on September 21, 2023. By the time notification was made, ten days had passed since Dr. Reece met with the leadership team on September 11, 2023 to memorialize his concerns. As Sarah Wilson testified, CPS, the agency for which she works, is specifically charged with doing “anything it can to keep abuse from happening.” Ms. Wilson outlined the rigid timelines that have been codified in Virginia. Once an allegation involving a child under the age of two (2) is made, an automatic 24 hour response is required because of the immediacy of the danger. If CPS had been appropriately notified on August 5, 2023, CPS would have had to respond by August 6, 2023 and the safety plan

that was not put into place until September 22, 2023 could have been put in place immediately. The Safety Plan, which included an observer program, might have made a material difference for subsequent babies. HDH's decision to defer notification was reckless and may have led to patient harm.

The Special Grand Jury believes that HDH's failure to follow state law in 2023 with respect to CPS reporting created confusion and the potential for harm. After interviewing various physicians who themselves are mandatory reporters, what emerged was that HDH utterly failed to provide guidance as to how and when the timing of CPS notification was to take place. Dr. Gardiner told the 2023 Joint Investigators that it was Dr. Gardiner's understanding that HDH upper management was to make notifications to CPS (which was eventually what happened, albeit it on a highly delayed timeline). Dr. Kuta believed that the policy for CPS notification at HDH shifted notification responsibility to the in-house neonatologists. Dr. Balint, one of the neonatologists, understood that CPS reporting was the responsibility of the HDH social workers. Notably, Dr. Balint consulted with colleagues and they were told that the matter would be "addressed" by HDH leadership. HDH's response to their realization that there was a concern in their NICU was to hire legal counsel from out-of-town and outside of their organization and commence internal investigation before notifying CPS. Dr. Holt thought that reporting requirements were satisfied by reporting to hospital administration. Nurse Pollard similarly believed that informing her supervisor would cover her obligations to CPS. Dr. Reece had a meeting with HDH leadership on September 11, 2023 to highlight his concerns and believed after that meeting that appropriate CPS notifications would be made.

Moreover, HDH's unilateral decision to forego the CPS Mandatory Reporting had negative implications for the 2023 Joint Investigation. By the time CPS was contacted at the end of

September 2023, the 2023 Joint Investigation was already fatally compromised by HDH's own investigation because all the witnesses had already been alerted to the existence of an investigation. HDH had already conducted its own internal investigation with a team of lawyers from an out-of-town law firm. They had collected the documents they believed were relevant, reviewed those documents, interviewed at least 20 witnesses, and removed Strotman from the nursing schedule. This was a tactic employed by HDH to avoid notification to the Board of Nursing. The full contours of that investigation and what it uncovered will never be fully known because of the defensive posture that HDH assumed in its retention of outside counsel, which was a maneuver designed to cloak the investigation in attorney-client and work-product privilege, so there is no way of ever knowing for sure what was uncovered.

The HDH internal investigation destroyed any investigative advantage that the 2023 Joint Investigation might have had by revealing that there were areas of concern that were localized to four specific victims. The placement of Strotman, and Strotman alone, on "administrative leave" was, in the opinion of the Special Grand Jury, remarkably problematic because by the time that the 2023 Joint Investigators were finally able to interview her (with a lawyer provided to her by HDH, no less), she was fully aware of what the allegations against her might be. By conducting an internal investigation before satisfying its CPS obligations, HDH prioritized the protection of the corporate entity over patient safety and threw a blanket of protection over the person who its own investigation identified as the central person of interest.

CPS reporting regulations exist for a reason: to use an investigatory function to protect vulnerable children. By delaying reporting and investigating, HDH circumvented the regulatory safeguards that exist to keep children safe. HDH's goals in their internal investigation were not aligned with patient safety and protection. If HDH had cared about protecting the vulnerable babies

in its care in 2023, they would immediately have put CPS on notice because CPS is uniquely situated to put protections in place for children and HDH would have immediately recognized that CPS intervention as beneficial, not deleterious. In conducting an internal investigation, HDH sought exoneration, not patient protection. HDH only made notification once its internal investigation ratified the erroneous theory of metabolic bone disease as the cause of the injuries.

HDH's lopsided investigation embraced the theory of metabolic bone disease, despite overwhelming concern from HDH's own radiologists and the outside expert that HDH consulted, a well-respected local pediatric orthopedic physician, Chad Aarons, MD. Had HDH been interested in truly understanding what happened to the victims of the 2023 Joint Investigation, Dr. Foster, a nationally recognized expert in child abuse medicine, was sitting less than ten miles away at VCU. In 2023, once the 2023 Joint Investigators got Dr. Foster involved, her opinion, one that ratified the opinion of the highly respected Dr. Reece, was that this was non-accidental trauma. Her opinion, which was also Dr. Reece's, was correct.

HDH's theory of "spontaneous fractures" in the context of metabolic bone disease was appealing to hospital administrators as they sought to limit liability. When interviewed by Ms. Negron as part of the Board of Nursing investigation into Strotman, the CEO of HDH, Ryan Jensen, continued to advance the theory of "spontaneous fractures," a theory that is contrary to the state of the medicine. This theory of "spontaneous fractures" is also contrary to the facts of this case, which documents Strotman in 2024 on video transferring her body weight onto various NICU infants of all different sizes. The reason for Jensen's position is obvious: if there is a reason why these fractures could take place without the bad acts of anyone at HDH, it reduces HDH's liability and allows HDH to continue business as usual.

c. The Failure to Report to the Department of Health Professions that Strotman Had Been Removed From the Nursing Schedule in

Materially Harmed the 2023 Joint Investigation and Delayed the 2024 Joint Investigation.

In 2023, while HDH was retaining outside counsel, it placed Erin Strotman on what it called "administrative leave". HDH offered that Strotman was on so-called "administrative leave" because she had contact with all four of the 2023 Cases victims. Strotman was placed back on this same type of leave in November 2024 when the first 2024 victim was discovered. HDH, at least according to Strotman, took the position that this was for her "protection" and not an adverse employment action. This was significant because it is the position of the Board of Nursing that when there is a concern that causes a nurse to be placed on administrative leave, the Board should be notified because it is an adverse employment action. Notably, when Strotman was placed back on administrative leave again in 2024, HDH failed to notify both law enforcement and DHP. DHP was not placed on notice of Strotman's change in employment status until she was terminated on January 2, 2025.

The failure to notify DHP in 2023 meant that DHP did not know about the concerns about Strotman so the investigation into her license, an investigation that could have uncovered her mental health condition and her increasing drug use, did not take place. DHP cannot investigate a nurse if they are not made aware of concerns. Similarly, DHP was not notified of Strotman's placement back on administrative leave in November of 2024 until January of 2025. While this delay was shorter, it would have been helpful to the 2024 Joint Investigation to know the information that was gathered by Ms. Negron in advance of the post-Miranda, custodial interview on January 2, 2025.

d. HDH's Belief Throughout the 2023 and 2024 Joint Investigations That the Observed Injuries Were The Result of Metabolic Bone Disease and "Spontaneous Fractures" Was Unreasonable.

The "spontaneous fracture" theory in the context of metabolic bone disease is unreasonable

both generally and as documented in the 2023 and 2024 Joint Investigations. For these two reasons, HDH's reliance on it was irresponsible and misguided.

Initially, the notion of spontaneous fractures is appealing: NICU babies, especially the sickest ones, are physically tiny and appear fragile. For these reasons, it seems to make sense that their bones would break for almost no reason at all. Dr. Foster explained why that theory is erroneous. These children are not moving or being moved very much at all, so bone breaks should be considered unexpected. Dr. Foster emphasized the rarity of unexplained fractures in the NICU population and offered support for her opinion with the 2021 CHoP Study.

This theory of "spontaneous fractures" in the context of metabolic bone disease is wishful thinking on the part of HDH, an entity that refused to acknowledge what was before it in plain sight. Various members of the administration and staff repeated it during both the 2023 and 2024 Joint Investigations. The problem with HDH's theory is that it is simply not true.

Dr. Shelton was working closely with the control center employees during the 2024 Joint Investigations: even against the backdrop of the 2023 Joint Investigation cluster of injuries, it was the articulated position of the HDH leadership team that the fractures came about because the 2024 victim babies had metabolic bone disease. The leadership team repeatedly rejected any hypothesis that inflicted injury was to blame for the injuries. Dr. Shelton was very concerned because HDH's assessment did not square with her understanding of the literature or the medicine, let alone the situation that she was observing as it unfolded in real time. At the beginning of the investigation, Dr. Shelton didn't know if the injuries were inflicted or caused by a quality of care issue. HDH never offered Dr. Shelton what the basis of its opinion that there were spontaneous fractures was, a position that Dr. Shelton found particularly concerning because she knows that it is possible to treat a child with metabolic bone disease who never suffers a single fracture. Dr. Shelton found it

both "puzzling and concerning" that by 2024, HDH's control employees continued to reject the hypothesis of inflicted injury. HDH's posture only changed after it saw videos of Strotman, and even then, the CEO of HDH continued to ratify the hypothesis of "spontaneous fractures" to Board of Nursing investigators.

As noted earlier, Dr. Foster dispelled the theory generally when she outlined the Children's Hospital of Philadelphia retrospective study from 2021, a high-quality, peer-reviewed study that looked at NICU fractures over the course of five years. Of the 5,656 babies whose records were reviewed, 28 had birth injuries and 57 had fractures that were not birth related. The fractures were almost always single fractures, not multiple fractures, and they were almost always in the context of children who were very ill and had poor metabolic bone health. Poor metabolic bone health simply means that these infants' bones are more vulnerable to damage with less force: but these bones don't simply spontaneously break. It continues to be true that metabolic bone disease can increase the likelihood of NICU bone fractures, but the entire point of fragile bone protocols like the one in use at HDH's NICU is to keep fractures from happening. The fractures almost always occur when a NICU infant has known risk factors for metabolic bone disease and has a bedside procedure.

Moreover, the spontaneous break theory fails with respect to the 2023 Joint Investigation victims for a variety of reasons that HDH should have evaluated. Dr. Foster reviewed the films and records for the four babies who were the subject of the 2023 Joint Investigation, and the evidence doesn't support that their metabolic bone health was poor. In fact, two of the four babies had none of the risk factors for osteopenia of prematurity. The other two babies had increased risk factors, but their labs didn't ever reflect enough change to constitute a formal diagnosis. In her testimony, Dr. Foster charted a conservative course: with respect to the 2023 babies, she was not

prepared to say to a reasonable degree of medical certainty that osteopenia of prematurity could be excluded as causation for any of the babies' individual preterm fractures, but she did say the observed injuries didn't align with the characteristic findings for babies with osteopenia of prematurity. Moreover, it was her opinion that the numbers of fractures and the cluster pattern were concerning for inflicted injury. Finally, HDH never offered any mechanism that made sense for accidental injury.

As an aside, Dr. Foster also pointed out basic medical coding errors that created the illusion of spontaneous injury when it did not exist. Specifically, Dr. Foster noted that the fourth baby who was the subject of the 2023 Joint Investigation was scanned for fractures at birth but didn't have any. His fracture, which Dr. Foster described as a "massive" transverse fracture to the left radius, so significant that it displaced the bone by an entire bone length, was incorrectly coded as a birth injury despite not being visualized until August 5, 2023 when seen on a babygram.

Dr. Foster was not asked to speculate as to why this injury was miscoded; nevertheless, the miscoding shifts causation for this tremendous injury that would have been immediately painful to this child and misassigns it as a birth injury, a mistake which is significant in the context of a cluster of injuries such as the 2023 cluster.

e. Documentation in the NICU in 2023 of both employees working with and procedures performed on NICU infants was poor and materially harmed the 2023 investigation.

When the 2023 Joint Investigators commenced their investigation, it became obvious that it was going to be difficult to determine which caregivers had access to which NICU infants, and that this would make effective investigation difficult, particularly because the investigation was beginning late, after HDH had already conducted their own investigation, and there were no in-room video cameras. By interviewing nurses, the 2023 Joint Investigators learned that each working nurse would be assigned to a specific baby or babies, but that all the nurses would help

each other out, and it wasn't unusual for nurses who were not assigned to specific babies to be in and out of individual rooms. These unassigned nurses were not documented in any meaningful fashion.

The documentation regarding medical procedures being performed was similarly spotty: in fact, HDH was eventually cited by the Virginia Department of Health because there was no documentation of which nurses were doing heel sticks or other medical procedures on the NICU babies. In short, by the time that the 2023 Joint Investigators and VDH completed their respective investigations, it was clear that HDH could not really tell with clarity who had access to which NICU infant or which nurses were handling which procedures.

This lack of clarity materially harmed the 2023 Joint Investigation. First, the 2023 Joint Investigators knew who was assigned to each of the 2023 victims, but could not tell who else had provided medical care to these children. Second, HDH was advancing the position that the observed injuries were the result of a combination of metabolic bone disease and handling processes, and HDH failed to appropriately document which nurses were in the chain of the handling processes especially the heel sticks. The 2023 Joint Investigators were able to develop two primary suspects, but more likely existed because of these HDH practices. This contrasts directly against the 2024 Joint Investigation, when the video cameras had been installed: the film could be observed and a suspect was developed.

f. HDH's Decision To Return Strotman To Work in the NICU Without Confirming She Was Drug Free and Psychologically Stable Enough When There Were Jobs With Less Vulnerable Patients Was Unreasonable.

HDH's decision to return Strotman to the NICU in September of 2024 ignored medical evidence, naively failed to require documentation that she was safe to practice with this acute patient population, and didn't appropriately safeguard patient safety with heightened training

requirements as she was reintegrated into the schedule. Moreover, there is no evidence that HDH either drug tested Strotman before they returned her to work or confirmed that she was psychologically stable enough to work with this vulnerable population. If HDH did not believe that they had a good reason to terminate Strotman in 2023, when they returned her to work, she could have been returned to a unit that had patients with lower acuity who could articulate a pain response.

Despite its placement of Strotman on administrative leave in 2023, presumably for patient protection, HDH nevertheless relied on the ill-advised paired theories of spontaneous fractures and metabolic bone disease to eliminate inflicted injury as the causative factor for the injuries to the victims in the 2023 Joint Investigation. Despite the contradiction of HDH's position by the literature, HDH's own radiology practice, Dr. Aarons' review of the records, and Dr. Foster's opinion about the genesis of the observed cluster of injuries, HDH refused to consider inflicted injury. Dr. Shelton remarked that she was concerned, at the beginning of the VDH's involvement in the 2024 Joint Investigation matters, HDH continued to take the "unreasonable" belief that the injuries that had been observed and were being observed again were the result of metabolic bone disease. While Dr. Shelton did not explicitly state this, the Special Grand Jury believes that HDH blindly adhered to its position when it was impossible to believe that what was being observed could ever been viewed as coincidental or accidental, particularly not by 2024. The Special Grand Jurors found that HDH's placement of Strotman on administrative leave in 2023 before HDH contacted CPS to be instructive: if HDH truly believed that the injuries were spontaneous, why did HDH place Strotman on administrative leave with pay? In the opinion of the Special Grand Jurors, this decision is incomprehensible.

HDH did not require Strotman to provide any records to document that she was stable

enough to work with this extraordinarily vulnerable population. There is no evidence that HDH sought to review whether Strotman had any psychiatric conditions, nor was she asked to complete any psychiatric evaluation or screening of any kind by HDH. There is no evidence that HDH reviewed Strotman's prescription history. She was never drug tested at any time during her employment and notably, she was never drug tested before she returned to work in September 2024. This blind refusal to execute these minimal safeguards is concerning considering what Sarah Scheer, who supervised Strotman in the NICU knew about Strotman's mental health in 2024. When Strotman returned to work in 2024, Strotman told Scheer that she needed to be on the day shift because Strotman was depressed and having trouble sleeping at night, so night work was difficult for her. It is not documented anywhere in the HDH materials that were provided to the Grand Jury that Scheer elevated that concern or made any changes to protect patient safety based on that information.

HDH has a policy that precludes the use of THC in the form of edibles/gummies. Strotman had a prescription for medical marijuana because of a fibromyalgia diagnosis, a prescription that she was filling. Because she was not drug tested, it is impossible to know if she was following the no-THC-edibles policy. HDH also has a policy that requires employee notification if there is the use of any medication that could impair work performance. During her brief return to work in 2024, it appears that Strotman continued to take her prescription for alprazolam, the generic for Xanax, but she never reported that to HDH, nor is there any evidence that she ever reported her prescription for THC.

HDH's reintegration for Strotman was deficient and ignored patient safety. Lisa James, the NICU nurse trainer received limited instructions as to what Strotman was supposed to be trained on when she returned to work in 2024: she was supposed to make sure that Strotman

completed the training mandated as part of the agreement with the Commonwealth's Attorney's Office and the new heel stick policy. The only additional training and supervision that Strotman received was from another NICU nurse, Dalanya Smith, Strotman's peer. Despite being out of work for over a year, there was no formal retraining process, no re-education on HDH's fragile bone protocol, and no re-initiation of the formal new NICU nurse training program. Smith was partnered with Strotman for four shifts to make sure that Strotman's reintegration to the unit was "smooth". By the third shift, Strotman told Smith that she didn't need supervision. It is notable that Strotman was the only person involved in the 2023 Joint Investigation who received this four shift integration back to the unit.

g. HDH's Failure to Monitor Nursing Interactions With Patients In Real Time in 2024, Especially After Strotman Was Returned to Work, And Its Decision to Block Out Sections of Video Was Poor Decision Making.

After the 2023 Joint Investigation, HDH made a substantial investment in surveillance equipment that HDH then utterly failed to deploy effectively.[10] While the Angel Eyes system was of limited utility for investigations, the Avigilon system was a robust and effective tool that HDH could have used to supervise Strotman as she was returned to work but did not. In fact, the Avigilon system was never used to monitor patient care in real time. To the contrary, the only time recorded footage was ever reviewed before the allegations in the 2024 Joint Investigation were raised was in a case involving hand-washing hygiene. The failure to monitor nursing care in the NICU after the 2023 Joint Investigation is indefensible. In 2023, HDH's position was that the observed fractures were not injuries of abuse, but rather spontaneous fractures heightened by

[10] HDH invested in two surveillance systems. The first, called the Angel Eyes system, was designed for parents to use to observe children when not in the hospital and operates like many systems employed at daycares. Notably, because of HIPAA concerns, the Angel Eyes system is disengaged when any medical care is being performed. The Avigilon system, on the other hand, is an in-room, constantly recording system equipped with effective zoom features to provide excellent surveillance at all times.

metabolic bone disease and quality of care handling issues related to NICU babies. There had been no documented incidents of fractures, non-accidental or otherwise, since Strotman was placed on administrative leave in 2023. After Strotman returned to work in 2024, HDH recognized the importance of giving her at least a little retraining and reorientation back into the unit. It defies logic that even if it was HDH's sincerely held belief that the injuries were quality of handling injuries that no one in a supervisory role ever used this excellent technological tool to observe Strotman as she reintegrated into the NICU work.

Similarly, the blanket decision to place large black boxes over major sections of the individual rooms is divorced from sensible decision making. While the stated reason for this decision was to protect nursing mothers, this decision also undermined the efficacy of video surveillance as an investigative tool and appears to have been implemented because it was the easiest thing for HDH, not the best thing for patient care, safety, and privacy. First, this concern could have been addressed by providing informed consent to the relatively small number of nursing mothers in the NICU. Second, this privacy concern would have been better addressed and more narrowly tailored if the decision had been made to black out actual nursing mothers who were nursing if surveillance footage had to be reviewed. HDH's thoughtless approach to the two chairs in the room meant that there was a lot of footage of nurses providing care to NICU infants in those chairs that could not be viewed during the 2024 Joint Investigation. When HDH was asked to remove the two boxes during the 2024 Joint Investigation, HDH did so immediately, reinforcing that their initial approach to the nursing chair privacy was what was easiest for HDH, not what best addressed this issue related to patient privacy.

h. HDH's Reliance on Attorney-Client Privilege to Avoid Providing Investigation Materials to VDH, the 2023 Joint Investigators, and this Special Grand Jury Left Unanswered Questions About What Happened Internally at HDH in 2023.

As the 2023 Joint Investigation snapped into focus, HDH's retention of outside counsel placed a protective shield around the results of HDH's internal investigation: there will always be ~~findings~~ information that remains secreted from law enforcement, CPS, VDH, and DHP. As Dr. Shelton testified, HDH would not disclose who placed Strotman on leave in 2023 or 2024 or why this decision was made. HDH would not disclose who made the decision to give Strotman a preceptor for her first four shifts back at work, or the reason for this decision. HDH did not disclose who decided that Strotman had been adequately retrained in 2024 when she was returned to work. HDH did not disclose who decided she did not need to be drug tested before she was returned to work in 2024. HDH did not disclose why no one monitored the videos in real time once they were installed.

Similarly, VDH could not learn what, if any, involvement HDH CEO Ryan Jensen had in the Strotman matter. Dr. Shelton does not know if Jensen approved Strotman's return to work in 2024. Jensen never disclosed the rationale for the lack of real time video review in 2024. Dr. Shelton believes that Ms. Scheer likely would have made a lot of the decisions about Strotman's employment and training, but HDH would not hand over these employment records, citing confidentiality and privilege. VDH was never able to learn how high up the reporting chain information about Strotman went.

Because of these assertions of confidentiality and privilege, assertions that could not be pierced by any reviewing authority, there are layers of unanswered questions about how Strotman was permitted to offend in 2023 and then returned to the same unit in 2024 when there were lower acuity units where she could have worked. HDH will never be compelled to produce this relevant material to the public, a public that relies on HDH to provide health care to those in need.

i. Even after the 2023 Joint Investigations, HDH Was Cavalier About NICU Patient Safety.

Even after four infants had unexplained, concerning fractures in 2023, HDH continued to adopt a posture that prioritized organizational preservation. The HDH theme of self-preservation was established in the delay in reporting to CPS in 2023 and continued as a narrative through Strotman's arrest.

Strong examples of HDH's posture were evident early on. Specifically, after the 2023 Level 1 finding identified the abuser as an "unknown hospital employee," HDH took the unusual step of seeking to have this finding amended by contacting the State Department of Social Services. HDH's concern was relayed back to Henrico Department of Social Services who declined to amend or set aside the finding. This is notable because there are now indictments returned against a person who was, in fact, a hospital employee.

As the 2024 Joint Investigation commenced, HDH pressed against the implementation of an appropriate safety plan. Despite having agreed to comply with the December 2, 2024 Safety Plan, it was discovered that HDH unilaterally failed to comply with the plan, a fact that was not discovered until the injuries to Baby L. M.-B. were discovered on December 17, 2024. When confronted with their non-compliance, HDH expressed resistance to compliance. During this call, HDH offered a neonatologist to try to offer the opinion that spontaneous fractures occur in NICU babies. Of note, the neonatologist offered did not give that opinion, and HDH ultimately (and reluctantly) agreed to comply with the December 2, 2024 Safety Plan, despite having been out of compliance with it for nearly three weeks. The misplaced reliance on the spontaneous fracture theory is a theme that is embroidered across the breadth and depth of both the 2023 and 2024 Joint Investigations and underpinned a series of decisions on the part of HDH.

The April 11, 2025 CMS report is replete with concerns for patient safety, some related to fractures and some that are unrelated. They are outlined in the summary of Dr. Shelton's testimony

but show an organization that lost focus on patient safety.

The concerns in the CMS report that are directly relevant to the 2024 Joint Investigation are: a radiologist failed to see a fracture that was visible and the fact that the radiologist failed to visualize the fracture was not reported to the chief medical officer as it should have been; HDH was not reviewing surveillance video to audit or perform observations of care; there was discontinuation of daily head-to-toe observations of NICU infants; the neonatologists who were being asked to screen for abuse had not been properly trained on what the signs of abuse are; and there was a discontinuation of notification of NICU baby concerns to the chief medical officer.

Concerns that were unrelated include a history of a significant MRSA outbreak; a failure of documentation of appropriate onboarding of nurses from other facilities; expired formula being given to NICU babies; and isolettes that were not being cleaned and sanitized properly.

Taken together, these failures show by the time of the 2024 Joint Investigation and the 2024 CMS investigation, the HDH NICU had become divorced from its patient safety mandate. It also bears mentioning that HDH never produced any of its internal investigation to law enforcement, CPS, VDH, or the Special Grand Jury. HDH retained counsel to determine what happened in the NICU, and then relied on attorney-client privilege to keep their findings hidden from public view.

j. HDH's Standards For Nurses Working in the NICU in 2023 Were Not High Enough.

When Strotman was placed on administrative leave in August 2023, she was a 25-year-old nurse with only an associate's degree from ECPI. She had been employed by HDH continuously since 2019 and it was the only job she had since graduation from ECPI. She was encouraged to return to school to pursue her bachelor's in nursing, but there is no evidence that she had started the application process for that degree. She had applied several times to work in the NICU. Her

direct supervisor, Sarah Scheer, said that she believed that Strotman's clinical skills were average (although she amended that opinion once shown the videos of Strotman nursing). None of the reviewing experts expressed any concerns about the propriety of HDH's training and onboarding program for the NICU.

Nevertheless, it remains true that Strotman had relatively less education, training, and experience than nurses at other institutions doing NICU work with similarly situated babies. For example, VCU requires nurses at its facility to have a bachelor's degree. Most of VCU's NICU nurses have extensive experience before they are permitted to work in that unit. VCU does not have any nurses in its NICU with ~~just~~ an associate's degree and less than five years of nursing experience.

VI. Discussion of the Summary of the Recommendations of the Special Grand Jury

As the Special Grand Jury heard the evidence from all witnesses, it became increasingly obvious that HDH's handling of Strotman's return to work after the 2023 Joint Investigation failed to consider sensible, low-cost precautions including measures like drug-testing that might have prevented the victimization of more NICU children in 2024. As Dr. Shelton so clearly articulated, HDH simply couldn't believe what was right before its eyes and what was being pointed out to it by professionals from the radiology, pediatric orthopedics, and child abuse disciplines. Moreover, because of assertions of privilege, the involved investigatory entities including CPS, VDH, and the CA's office did not have all the tools that they needed during the critical time periods both in 2023 and 2024. Finally, the relative rarity of this event should transform it into a teaching tool: the involved entities should create materials so that other agencies who encounter a similar fact pattern have materials available for their review so that harm to future NICU infants is mitigated.

a. Recommendations For HDH

i. The mandatory reporting law of the Commonwealth should be posted on its website, in every patient room, included in welcome packets for new NICU parents, as well as being reviewed with every newly-onboarded individual who works with children and reviewed annually with every individual who works with children.

HDH unacceptably delayed notification in what became the 2023 Joint Investigation for a period of nearly six weeks. HDH used that time to conduct an internal review with an outside law firm, thus cloaking that investigation in attorney-client privilege and keeping their results and findings hidden from external review and the court of public opinion. Since that failure, all HDH employees involved in the chain of care for children have received training and education about the symptoms of child abuse and neglect and reporting requirements. Of additional concern, on September 6, 2023, a grandmother of one of the injured 2023 infants made a CPS complaint after learning that her grandchild had a fracture. Instead of joining the CPS notification and getting an investigation started, professionals inside of HDH provided information that caused a flawed screen-out by CPS.

HDH now understands its CPS reporting obligations because it immediately reported in 2024 and continued immediate reporting throughout the pendency of the 2024 Joint Investigation. The policy worked in 2024 and saved valuable investigatory time which helped lead to the arrest of the appropriate suspect.

The policy will only continue to work if there is continued institutional education and awareness of the policy. For this reason, the Special Grand Jury recommends that HDH's articulated policy for CPS notification and the obligations of mandatory reporters be placed in every NICU patient room. Moreover, it is the recommendation of the Special Grand Jury that an explanation of the policy be included with all other parent admission/onboarding materials, and that the admissions materials be amended to include a section where there is parental acknowledgement of receipt of the policy.

Of course, there will be times when new individuals commence work with children at HDH. Every individual who interacts with children must receive detailed education on HDH's policy and that must be documented in training/employment records. Moreover, it is the strong recommendation of the Special Grand Jury that the policy be reviewed and acknowledged in writing every year by every individual who works with children.

ii. Any family complaint to CPS will require the assignment of an ombudsperson who will assist the family through the process involving CPS as the family's advocate.

As Ms. Scholla, the CPS supervisor involved in both the 2023 and 2024 Joint Investigation explained during her testimony, on September 7, 2023, a grandmother of one of the 2023 infant victims tried to exercise self-help by contacting CPS and filing a report for concern nearly two weeks before HDH formally made the notification to CPS through CPS' intake procedure. Even though the grandmother was an experienced nurse and now it has been proved that she knew exactly what she was seeing, CPS nevertheless screened out her concern after it called HDH, spoke to one of the infant's physicians, and was told that the grandmother's concerns were unfounded. HDH was already on notice that there were other children with fractures by September 7, 2023, a material fact that likely would have made a difference to the screening supervisor. The physician working inside of HDH who erroneously allayed CPS' concerns no doubt was seeing the personnel in the NICU in the best possible light at just the time that a more discriminating eye would have been helpful. If CPS had been given more accurate, more comprehensive information, it could have acted faster and better.

For this reason, the Special Grand Jury recommends that at HDH's expense, a person, preferably a trauma-informed social worker, be identified to be an ombudsman in the rare event that there is a CPS complaint from a family member of a NICU patient at HDH. This ombudsman will be charged with working with CPS intake to provide a more comprehensive picture of the

reason for the call for concern. This person should be clearly identified on the materials that are placed in patient rooms and in the admissions materials.

iii. Random, contemporaneous video reviews of patient care in the NICU should be conducted for every employee every quarter and specific written feedback should be provided to each employee.

HDH installed, at what was likely significant expense, the very advanced Avigilon surveillance system after the 2023 Joint Investigation and then didn't use it in any meaningful way. There is documented evidence that HDH supervision knew how to use it: when there was a complaint about handwashing hygiene, HDH supervision was able to access and review the footage. Despite that, and even though HDH had placed Strotman out of work on administrative leave in 2023 and had kept her out of work for about a year, there was no evidence that anyone in Strotman's chain of command used this system to review her skills (or anyone else's for that matter). What is particularly concerning about this is that if anyone had been watching Strotman regularly, it would have been immediately obvious that her clinical skills dipped from average to poor when no one was watching.

The Special Grand Jury therefore recommends that a system of random contemporaneous video reviews take place for every individual working in the NICU no fewer than 10 sessions of 30 minutes each. This should be enough frequency to develop a clear picture of what is happening in nursing care in the individual patient rooms. While there is true benefit to private patient rooms in the NICU, the drawback to a move from the large, multi-isolette patient bay is that individual nursing care is not easily observed. This suggestion tracks one that was made by the VDH as part of the consent agreement, and its benefits are obvious. This should be documented and made part of individual employee evaluations.

iv. Quarterly mandatory in-services about issues related to child safety standard of practice should be conducted.

In 2023, the prevailing belief of HDH's professionals was that HDH NICU infants were susceptible to spontaneous fractures. In fact, Strotman herself told her interrogators that one of the neonatologists told her that even having a baby bear weight on his feet could have caused the observed fractures. The Special Grand Jurors believe that part of the reason that Strotman believed she could be rough is that this position empowered her to believe that no matter what she did, fractures could still happen, so there was no point in being particularly careful. This anecdotal misunderstanding not only flowed to inexperienced nurses like Strotman, but it was also ratified by hospital administration at the highest level, including the CEO.

This fundamental misunderstanding of fragile bone protocol highlights the need for better clinical skills information across the entire HDH NICU. There is no reason to believe that everyone providing care for these infants from the CEO all the way down to Strotman, a relatively inexperienced nurse, was lying about what they understood the overall breakability of NICU babies' bones to be but the fact remains what these professionals believed was just wrong. This misunderstanding provides the basis for the Special Grand Jury's recommendation that there be quarterly mandatory in-services of one hour in duration related to child abuse in the context of NICU care. This professional education should also be required of everyone in the chain of command for the NICU team all the way to the CEO of HDH.

v. A mandatory annual in-service on HDH's fragile bone protocol that includes the latest research on NICU fractures should be conducted.

The best current study regarding the susceptibility of NICU infants is the 2021 CHoP Study, which was outlined for the Special Jury by Dr. Foster as she testified. This study highlights the relative rarity of a fracture for a NICU infant (still only about 1% for the very sickest, highest-acuity NICU infants) and the risk factors that make an individual NICU infant susceptible to fractures.

The HDH professionals did not reference that study in their interviews in either the 2023 Joint Investigation or the 2024 Joint Investigation. Additionally, at no time did anyone working inside HDH highlight for the 2023 or the 2024 Joint Investigators about the individual risk factors for individual victims. Instead, there was an overarching posture throughout the investigation, even after Strotman was observed on video and arrested, that these fractures just happen. In fact, to explain why HDH should not be required to comply with the December 2, 2024 Safety Plan, HDH tried to convince a west coast neonatologist to ratify this flawed opinion, which the neonatologist declined to do.

The Special Grand Jurors believe that HDH did not understand the state of the medicine with respect to bone fragility and the relative rarity of fractures in the context of the NICU. For that reason, the Special Grand Jury recommends that HDH implements an annual all-NICU in-service that focuses on HDH's fragile bone protocol. It is recommended that HDH's fragile bone protocol be aligned to reflect the latest research around these issues, whatever that may be. Because of the continued institutional bias expressed by the CEO of HDH which presented as a resistance to altering his opinion as recently as March 2025, it is further recommended that the materials that underpin this recommended in-service be prepared by someone who is not employed by HDH. It is the specific recommendation of the Special Grand Jury that HDH consider the retention of professionals who conducted the 2021 CHoP Study conduct the initial training and record it so that it can be reviewed by newly onboarded individuals when appropriate.

vi. HDH should place a board-certified Child Abuse physician on its staff and every CPS referral that is made should be contemporaneously sent to that physician for review and comment.

When conducting its analysis of the facts that underpinned the 2023 Joint Investigation, HDH recognized the need for outside expertise and analysis of the medical records, which they sought in the form of the opinion offered by Chad Aarons, MD, a well-regarded pediatric

orthopedist. However, in the framework of concern for non-accidental trauma and a CPS report, all the CPS and law enforcement experts immediately turned to Dr. Foster, a nationally recognized expert in child abuse medicine. This decision was logical and appropriate in the context of a CPS referral that became a joint investigation.

In 2023, the evidence reflects HDH's resistance to considering even the possibility of abuse. HDH finally called CPS after 6 full weeks and its own internal investigation, presumably because of Dr. Reece's documentation of concern in the medical records. Valuable time was wasted while HDH sought answers that could have easily been provided by Dr. Foster and her decades of experience of evaluating the manner and cause of various symptoms of trauma.

The Special Grand Jury therefore recommends that HDH establish an expert retention policy with respect to child abuse. When either concern for non-accidental injury is established or a CPS report is made, a board-certified child abuse physician, who will be placed on staff by HDH, will be notified and immediately consulted as an expert. Placing a board-certified Child Abuse Physician firmly in the chain of review for these relatively rare but extremely concerning events would provide an additional prophylactic level of protection to these vulnerable and voiceless victims.

vii. A BSN and 5 years are a mandatory minimum requirement for employment as a NICU nurse.

HDH's requirements for employment in the NICU are, in the opinion of the Special Grand Jury, not rigorous enough and fail to appropriately provide patient protection. At VCU, nurses are required to have a bachelor's degree in nursing. Moreover, desirable positions in the NICU at VCU are reserved for highly experienced nurses. Strotman was barely minimally qualified to do the work that she was doing in the NICU with just an RN and no articulated plan to return to school to seek her BSN. She hadn't been a nurse for very long and started her career during COVID. In

August of 2023, she had been in the NICU for only a little over a full year. She had completed the onboarding process, which all reviewing experts agree was sufficient, but little else.

It is the opinion of the Special Grand Jury that HDH should not permit anyone to work in the NICU who does not possess a BSN and who has not had five years of experience. Even HDH acknowledges that experience makes a difference: that was the reason that it gave for placing Strotman and not another more experienced nurse out of the NICU in 2023.

Finally, it is the recommendation of the Special Grand Jury that any nurse who will be employed in this unit be required to complete a pre-employment psychiatric/psychological screening to establish evidence of good mental health before employment in the NICU commences.

viii. HDH should, at its own expense, conduct a study to determine whether providing housing for these vulnerable infants in private rooms or in a semi-private or pod housing concept for better patient care and better safety.

The Special Grand Jury recommends that HDH conduct a study to determine if private patient rooms are better for patient care than semi-private rooms or large NICU rooms with bay style setup. During the 2023 Joint Investigation, the 2023 Joint Investigators noted that one major challenge to identifying who the offender was that each baby in a private room was receiving care from nurses who were not on the schedule as assigned to that particular baby. This was because the NICU nurses were using a team system so that they could assist each other in the care of infants. Unfortunately, it also meant that the care of individual infants by individual nurses was not effectively documented. This failure of documentation was also noted by VDH when it conducted its first review of HDH and found inadequate recording with respect to HDH's heel stick procedure.

While the Special Grand Jury certainly understands that private rooms might be appealing

as an amenity to families in the NICU, it also continues to believe that private rooms made it easier for the abuse that is documented on video to happen. If there has been semi-private rooms, or even an older style "bay" system, more eyes would have been on Strotman, and it is universally agreed, even by Strotman herself, that the care that she provided when she was alone in the room with an infant was materially worse that the care that she provided when someone else was in the room with her.

ix. Mandatory prescription drug checks and mandatory random drug screens will be required for employees who are assigned to the NICU.

While HDH retains the right to check the prescription history of its employees and to conduct random drug screens of its employees, Strotman's prescription drug history was never analyzed nor was she ever drug tested. While it is unsurprising that she was not drug tested as part of the 2023 Joint Investigation, it was concerning to the Special Grand Jury that she was not drug tested as part of the 2024 Joint Investigation and incomprehensible that she was not drug tested as part of her return to work protocol. Additionally, HDH's policy that an employee self-report if using prescription drugs that might affect that is unreasonable in its naivete. In Strotman's case, when she told her supervisor Ms. Scheer that she was depressed when she returned to work in 2024, Ms. Scheer acted to try to help Strotman by moving her to a daytime shift. While Ms. Scheer's concern for her employee was admirable, it failed to consider the safety of the NICU infants for whom this confessed depressed person was providing nursing care. Additionally, the Special Grand Jury noted with concern the stark variation between Strotman's behavior when she was with her colleagues and when she was alone, especially the videos of concern that show her losing her balance and rolling on the floor with one of her NICU patients in her arms. After reviewing this video, the Special Grand Jury believes that Strotman was able to behave in a normal

manner when she was being observed by colleagues but then fell apart when left alone in patient rooms.

One way to ensure a NICU nursing population that is free of issues related to drug abuse is to compel the nurses on this unit to agree not to use any illicit or controlled substances, including marijuana which continues to be classified as a Schedule I substance and illegal federally. There is absolutely no reason not to drug test nurses who are working with NICU infants. Similarly, there is no reason not to require these nurses to sign a release that permits review of their prescription histories. Individuals in all different professions, including law enforcement and firefighting, are regularly required to submit to similar testing. For that reason, the Special Grand Jury recommends that all nurses who work in the NICU be drug tested at regular intervals and provide their consent for review of their prescription histories at regular intervals.

x. The onboarding period for NICU nurses and its accompanying curriculum/buddy period will be extended to 9 months.

While every expert who reviewed the HDH onboarding and orientation process for new NICU nurses found it to be adequate, it is nevertheless abbreviated at only three months. Moreover, while it is obvious from the interviews that the NICU nursing staff was eager to help each other, once the onboarding process is over, because of the private NICU rooms, the nursing work is solitary in nature. Strotman's path through the NICU is instructive. It took her several tries to achieve a transfer to that unit, but one she did, she began her onboarding process in late May of 2022. The process concluded by September 2022, and she had patient assignments of relatively low acuity patients as she began her career. To be sure, Strotman was described as bubbly and vivacious, and because she appears to have been well-liked by those around her who were not observing on a daily basis, she apparently developed nursing habits that were sloppy and dangerous and incorporated strategies that she created from whole cloth that HDH never taught

her. By August of 2023, the first non-accidental fractures were reported. While HDH's training protocols may be adequate, they certainly were not adequate for her.

Because of the systemic failures that caused Strotman to substitute her own judgment for the evidence-based clinical skills that she should have been using, the Special Grand Jury recommends that the onboarding period for new NICU nurses be expanded to a period that is closer to nine months. While everyone agrees that the training program that was in place during Strotman's onboarding is clinically appropriate, the Special Grand Jury nevertheless recommends a substantial expansion of the preceptorship period to make the total length of onboarding nine months. This recommendation contemplates that the new NICU nurse would be working side by side with the preceptor after the more intensive on-the-job clinical skills course is completed.

xi. Any time a nurse is taken off the schedule or placed on administrative leave, DHP will be informed.

During Ms. Negron's testimony, she advised the Special Grand Jury that a health care entity like HDH is required to notify DHP if it takes an adverse employment action against an employee. It was the position of HDH that Strotman's pivot to "administrative leave" in 2023 was not an adverse employment action against her, a position that they continued to maintain during the course of 2024. It was not until she was terminated in 2025 that DHP became aware of the concerns about Strotman and her ability to deliver nursing care in a safe manner. This delay in informing DHP had the same detrimental effect that the delay in CPS notification did: it kept the professionals from reviewing agencies at the county and Commonwealth who are charged with patient care from being able to keep patients safe. Every Human Resources professional should be placed on notice of this policy, and every HDH employee whose license is monitored by DHP should be required to sign documentation that they understand this policy and that they recognize their duty to self-report should they be placed on administrative leave.

It is the belief of the Special Grand Jury that being placed on administrative leave or being "taken off the schedule" while still being paid is an "adverse" employment action. Once that action has taken place, HDH is required to notify DHP. HDH should create a policy that reflects this position rather than obfuscating with semantics.

b. Recommendations for DSS/CPS

i. Implementation of spot checks for compliance when an entity that provides health care is the subject of a safety plan.

On December 2, 2024, CPS and HDH executed a safety plan to protect NICU infants that HDH then interpreted in a way inconsistent with the language and spirit of the plan itself. This was discovered only when CPS made a return trip on December 17, 2024 when there was a novel CPS referral for a new injury. At that point, HDH had used its modified version of the December 2, 2024 plan and was resistant to implementing the plan as written. The Special Grand Jury was alarmed to learn that HDH was not in compliance with the plan and no one knew until another injury presented and CPS came back out to HDH to find non-compliance.

In cases involving health care entities, the Special Grand Jury recommends in the strongest terms that CPS/DSS conduct an unannounced review every 10 business days to confirm organizational compliance. As Ms. Scholla noted, one of the challenges for CPS is the enforcement of non-compliance. As she learned during the 2023 and 2024 Joint Investigations, there is no one in Virginia who currently holds the regulatory to close just the NICU of a hospital: the whole hospital must be closed to achieve that goal. For that reason, this recommendation goes hand in hand with the recommendation to Virginia's General Assembly that it pass regulations that address non-compliances with safety plans in the context of a hospital or health care entity.

ii. CPS investigators and supervisors should be empowered with appropriate knowledge to challenge medical opinions that are presented to them.

In 2023, when the screening supervisor received the first CPS complaint from the nurse-

grandmother two weeks before HDH finally self-reported, the supervisor did not have enough information to make an informed decision about whether to screen the fracture in for more investigation. Without enough information, she acted sensibly by calling HDH's NICU, where she spoke with a neonatologist who ultimately gave her information that can only be viewed as biased in favor of HDH and not patient-centered even though that was the timeframe around which Dr. Reece was expressing concern and HDH was hiring out-of-town counsel to protect its rights and not the health of victim children.

CPS should create a working library of articles and literature that articulate the state of the medicine for all non-accidental injuries in health care situations and make sure that the intake supervisors and CPS investigators receive at least minimal training and education regarding commonly observed injuries that are concerning for inflicted injury. Had the intake supervisor had access to even a synopsis of the 2021 CHoP Study, she would have known better screening questions to ask, and an investigation might have opened two weeks earlier than it did.

iii. Create a database of administrative/regulatory/licensing agencies that handle licensure for health care entities.

Ms. Scholla, who was tasked with interacting with HDH's leadership, was frustrated during the pendency of the investigation because she did not know who the appropriate licensing/regulatory contact for HDH was, and it took HDH an exceptionally long time to get that information to her. As she related it, she realized that she did not have any statutory authority to close the HDH NICU, in much the same way she does not possess the authority to close a daycare with an offender or one that refuses to comply with a safety plan. For that reason, she wanted to know who licensed the HDH NICU to coordinate response with them, information that was withheld by HDH.

CPS should never be dependent on the subject of the investigation, in this case HDH, to

provide key contact information about licensing to CPS. For this reason, the Special Grand Jury recommends that CPS prepare a directory of contact information for the various licensing entities for health care and other caregiving entities. That material should be circulated to every investigator, all the CPS supervisors, and everyone else in a supervisory role in CPS/DSS, all the way up to the Director of Henrico's DSS, Gretchen Brown, so the delays in notification that occurred in the 2023 Joint Investigation do not happen again.

iv. Coordinate and execute meeting with investigators at DHP/VDH to facilitate coordination of investigation on going-forward basis.

Similarly, CPS investigators did not know who their counterparts at the various entities are because the coordination and connections were initially not smooth. There were a lot of involved entities at various times and none of the investigators or supervisors knew each other which made institutional/agency information sharing more difficult than it needed to be and may have caused duplication of effort in some places.

The Special Grand Jury recommends that CPS absorb the lessons learned from this unusual investigation by memorializing the various positions of responsible individuals in other agencies. If there is a similar investigation that takes place at a health care provider in Henrico County again, it will be helpful to have a document that reminds all involved parties of the individuals at each agency who should be contacted and what authority each has.

b. Recommendations for the CA's Office

i. Coordinate/execute informational sessions with lawyers for various regulatory entities to facilitate communication/information in periods of crisis.

The lack of coordination was not confined to the investigatory level of this investigation alone. As Ms. Scholla recounted, working across all the agency lines was complicated and eventually involved the lawyers who represented VDH and DHP. Of note, the lawyer who

represented the DHP investigators is not the same lawyer who represented DHP in Strotman's summary suspension proceeding, who is also the same lawyer who will represent DHP in its full hearing in front of the Board of Nursing. That lawyer's supervisor, who is also a lawyer, has also had substantial involvement in the summary suspension and will be intimately involved in the full suspension hearing.

Now that the institutional knowledge exists, the Special Grand Jury encourages the Office of the Commonwealth's Attorney to memorialize it so if a similar matter presents itself in years to come, whoever is assigned to handle that case can review the work that was done in this particular matter.

ii. Offer professional development opportunities for other stakeholders to include DSS/CPS investigators, law enforcement, and prosecutors.

This matter is unusual but not unique: child abuse and neglect matters fall into several broad categories and the fact patterns present in similar fashions repeatedly. This is illustrated by Dr. Foster's ability to produce a study that looked at all the fractures that took place at Children's Hospital of Philadelphia, none of which were proved to be intentional or inflicted and by her ability to recount an event that took place with an abusive nurse in Wisconsin in 2019 where a cluster of injuries was uncovered and successfully prosecuted.

As the Special Grand Jury watched the evidence unfold from the 2023 Joint Investigation and the 2024 Joint Investigation, it was obvious that this investigation and the accompanying prosecutorial decisions were complex not because of the individual cases were particularly difficult but because of the sheer volume of players, including but not limited to victims, civil lawyers, investigators who were directly involved, investigators from other entities, and the amount of investigatory material that was generated. Because of these challenges, the Special Grand Jury recommends that the Henrico County Commonwealth's Attorney's office prepare

continuing education materials around lessons learned from these matters. The Special Grand Jury recommends that a representative from the CA's office partner with Ms. Scholla and personnel from HPD to prepare a recorded continuing education class that can be offered statewide on an asynchronous basis.

c. Recommendations for the Virginia General Assembly

It is obvious that there are easy legislative changes that could be made to keep NICU babies safer inside of NICUs in Virginia. There were various points at this process when CPS, VDH, and the Commonwealth's Attorney's Office would have used stronger or different tools in the Code of Virginia to better to protect NICU babies if the tools had existed.

i. Expand the power of VDH to suspend the license of an individual unit, not just the entire hospital through legislation.

On July 23, 2025, Dr. Shelton told members of the state's Joint Commission on Health Care Wednesday that the Department of Health has "limited actions" that it can take related to "hospital accountability for protecting the health and safety of patients." As Dr. Shelton had previously told this Special Grand Jury, "We can revoke or suspend a license, but it's for the entire hospital, which would be a very drastic situation for healthcare needs, especially in some communities that don't have multiple hospitals…We cannot currently impose intermediate sanctions on hospitals at this time." The Special Grand Jury would be foolish to look past how the revocation or suspension of the license of a large hospital like HDH for an issue related to the NICU could create access to care problems for Henrico County residents who depend on HDH for their health care needs.

That said, the Special Grand Jury recommends that the Virginia General Assembly addresses this issue through legislation that confers the authority to suspend or revoke the license of one unit in a hospital. This would have made it infinitely easier for Dr. Shelton to immediately

close the NICU in 2024, something that she was hesitant to do in part because it would have meant closing the entire hospital right at the holidays.

ii. Expand the power of VDH and DSS/CPS to fine hospitals that continue to be out of compliance through legislation.

Currently, VDH does not have the statutory authority to fine hospitals for being out of compliance. This contrasts from VDH's ability to fine nursing homes, a specific authority that was granted to it earlier in 2025. Neither did DSS/CPS have any authority to impose fines for failure to comply with safety planning. Both VDH and CPS were in difficult positions. VDH didn't want to close HDH entirely but had grave concerns about patient safety. CPS had a safety plan that wasn't being complied with but quickly realized that the typical enforcement mechanism for noncompliance, removal of the victim child, wasn't possible because the victim children didn't need to be removed from their parents and some were too medically fragile to be moved from HDH.

The Special Grand Jury therefore recommends that the regulatory structure be changed to permit VDH and CPS to impose fines for noncompliance if found by VDH. Moreover, the Special Grand Jury recommends that the legislature amend the authority of DSS to create a structure that permits it to fine healthcare entities that fail to comply with agreed-upon safety plans.

iii. Amend § 63.2-1509 of the Code of Virginia to make failure to report physical abuse of a minor crimes jailable offenses.

In pertinent part, subsection D states that "[a]ny person required to file a report pursuant to this section who fails to do so as soon as possible, but not longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall be fined not more than $500 for the first failure and for any subsequent failures not less than $1,000. In cases evidencing acts or attempted acts of rape, sodomy, aggravated sexual battery, or object sexual penetration… a person who knowingly and intentionally fails to make the report required pursuant to this section

is guilty of a Class 1 misdemeanor."

It is the recommendation of this Special Grand Jury that the code be amended to reflect that the first failure to report any physical abuse crime against children be reclassified as a Class 1 misdemeanor, and any subsequent failure be a Class 6 felony.

iv. Create an additional offense in the Code for health care providers who commit abuse crimes against children in their care.

Section 18.2-371.1 of the Criminal Code of Virginia addresses child abuse. It classifies child abuse as either a Class 4 or a Class 6 felony, depending on the elements established: if "Any parent, guardian, or other person responsible for the care of a child under the age of 18 who by willful act or willful omission or refusal to provide any necessary care for the child's health causes or permits serious injury to the life or health of such child is guilty of a Class 4 felony." Further, if "[a]ny parent, guardian, or other person responsible for the care of a child under the age of 18 whose willful act or omission in the care of such child was so gross, wanton, and culpable as to show a reckless disregard for human life is guilty of a Class 6 felony." The current code section does not enhance punishment if the offender is a health care provider.

The Special Grand Jury recommends that a change be made to this statute. Specifically, the Special Grand Jury recommends that if the person responsible for the care of a child is a health care provider that the Class 4 felony be enhanced to a Class 3 felony, and if the caregiver is a health care provider the Class 6 felony be enhanced to a Class 5 felony.

v. Create legislation that prohibits any health care entity from designating documents or investigation as protected by attorney-client privilege in a child abuse or neglect case.

HDH has protected the results of its investigation from public view by effectively implementing a two-part process. First, HDH didn't notify CPS and second, they used the time buffer that the failure to report created in order to retain outside counsel to conduct a

comprehensive investigation that is attorney-client privilege protected. There will always be information about this investigation that HDH knows that other important stakeholders like law enforcement, CPS, VDH, and DHP never has access to for important public protection purposes because HDH has asserted attorney-client privilege, which currently has no limitations.

No hospital should be trusted with patient care and simultaneously offered a means by which it can keep details of an internal investigation related to that same patient care shielded from reviewing governmental entities. The conflict of interest is obvious: this assertion of privilege guts the enforcement mechanisms that are intended for public protection.

For this reason, the Special Grand Jury recommends that the General Assembly create legislation that prohibits any health care entity from designating any document or investigation as being protected by attorney client privilege. This limitation on privilege has been adopted before. For example, in § 19.2-271.2 of the Code of Virginia, the marital privilege may not be asserted "in any proceeding relating to a violation of the laws pertaining to…abuse of children." The General Assembly could create a similar limitation in cases like this one.

VII. Conclusion

The Special Grand Jury was honored to serve the people of Henrico County in this important role that ultimately serves to protect our County's most vulnerable citizens. It is the sincere hope of the Special Grand Jury that those who evaluate and review this report will understand the hard work that was done to review the evidence, make the findings, and issue the recommendations[11].

The members of the Grand Jury would offer our deepest sympathy to the beautiful little babies that were so grossly abused and their families. We sincerely hope that this report and

[11] The members of the Special Grand Jury appreciate the outstanding work of the team at the Henrico County Commonwealth's Attorney's Office who handled this matter.

recommendations will help prevent this horror from ever happening again.

The members of the Grand Jury will continue to pray for the healing of the injuries these precious babies endured and the heartbreaking trauma the families had to endure.