Special Grand Jury Exhibits

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Exhibit A: Summary of Testimony from Sergeant Matthew Fitzer, Henrico Police Division and Sarah Wilson: February 7, 2025 and February 21, 2025

Sergeant Matthew Fitzer and Henrico County Child Protective Services ("CPS") Investigator Sarah Wilson were the joint lead investigators assigned to the 2023 Joint Investigations. Sgt. Fitzer has been employed for 16 years with Henrico County's Police Division ("HCPD"), where he has served in increasingly responsible positions. Sarah Wilson, the CPS investigator assigned to conduct the joint investigation with Sgt. Fitzer, holds her master's degree in social work and has been employed in increasingly responsible roles with Henrico CPS. The Special Grand Jury received exhibits from these two witnesses, including a complete copy of Sgt. Fitzer's investigative report with his entire file. Similarly, the Special Grand Jury received a complete copy of Ms. Wilson's report, along with all the supporting documents she relied on in the course of her investigation. The Special Grand Jury found the testimony of both witnesses credible.

These two joint investigators, Fitzer and Wilson identified the four 2023 victims, Z.M., T.M., M.L., and N.H. and described that the CEO of HDH, Ryan Jensen, and the then-VP of Quality, Denise Weisberg, were the two individuals who made the first report to Child Protective Services on September 18, 2023. Joint investigations in cases involving child abuse are preferred for a variety of reasons. HCPD does not have the authority to put a safety plan in place during the pendency of an investigation: that function is reserved for Henrico County CPS. As a CPS investigator, Ms. Wilson's role was to receive reports of concern for child abuse from mandatory reports and other interested parties and determine if the report of child abuse is valid. If it is determined to be valid, CPS implements services to do anything it can to keep abuse from happening again.

These joint investigators testified that the first 2023 Cases injury was identified on August

5, 2023, approximately 6 weeks before the injury was reported to CPS, which received notification on September 18, 2023. Ms. Wilson was assigned to the 2023 Joint Investigation on September 21, 2023 at 2:36pm. It was identified as a matter that had a required 24-hour response time. In Virginia, if an allegation of abuse of a child under the age of two (2) is made, an automatic 24-hour response is required because of the immediate nature of the danger.

Once CPS was notified, CPS made a referral to notify HCPD on September 21, 2023. The joint investigation to see if criminal conduct existed commenced when the matter was assigned on September 22, 2023 (the "2023 Joint Investigation"). At no time did anyone at HDH notify HCPD that they had a cluster of unexplained fractures in infants in the care of HDH's NICU.

In 2023, Sarah Wilson was the most experienced investigator in Henrico's CPS office, which is why this matter was assigned to her. She immediately reached out to Sgt. Fitzer so that they could coordinate efforts and prepare a Safety Plan for the children affected by the 2023 Cases. The initial Safety Plan required an "observer" protocol: each person who could be identified as having contact with a majority of the 2023 Cases victims was required to be supervised in the NICU by an observer. The initial Safety Plan and the subsequent Safety Plans were signed off by individuals in HDH's administrative framework, including Denise Weisberg, who was one of the initial reporters to CPS.

The joint investigation began quickly because of concern about potential harm to vulnerable infants. Investigators first observed injuries were not related to the birth process for any of the 2023 Cases. During their testimony, both Sgt. Fitzer and Ms. Wilson outlined a key piece of evidence, a document entitled "Windows of Opportunity" created by Dr. Gerry L. Reece. Dr. Reece was the first radiologist at HDH to express concern that the observed injuries to the victims in the 2023 cases were inconsistent with accidental injury and consistent with inflicted

injury. The "Windows of Opportunity" document established when the observed injuries of the 2023 victims would have been caused based on the observed healing of the various injuries.

Sgt. Fitzer and Ms. Wilson both testified that by the time that CPS/HCPD commenced the 2023 Joint Investigation, HDH had already conducted its own internal investigation and had interviewed approximately 20 potential witnesses. Moreover, by the time the 2023 Joint Investigation began, Strotman had already been placed on administrative leave by HDH. HDH told Sgt. Fitzer and Ms. Wilson that Strotman was on leave was because she had contact with all four of the 2023 Cases victims. Sgt. Fitzer and Ms. Wilson also learned that by the commencement of the 2023 Joint Investigation, there was another individual with contact with all four of the 2023 Cases victims, but he was not placed on administrative leave. This employee was not placed on administrative leave because he had worked at HDH for twenty-seven (27) years without incident. When asked why Strotman was on leave and this professional was not, HDH offered as explanation that Strotman had only worked for the NICU for about a year.

Sgt. Fitzer and Ms. Wilson continued with the 2023 Joint Investigation and conducted witness interviews on October 5, 2023. All the interviews that were conducted were recorded, as is standard practice. On October 9, 2023, Sgt. Fitzer and Ms. Wilson attended a meeting regarding the 2023 Cases with lawyers from HDH, lawyers from the Commonwealth's Attorney's Office, and Robin Foster, MD, a Child Abuse Pediatrician who is a professor at Virginia Commonwealth University's ("VCU") School of Medicine. During that meeting, HDH ratified their position that the observed injuries on all four 2023 Cases victims were either accidental in nature or caused because the 2023 Cases victim were unusually susceptible to injury. Dr. Foster expressed skepticism with respect to HDH's position as to the injury pattern causation and opined that she was gravely concerned for non-accidental or inflicted injury. Dr. Foster had been given the

Windows of Opportunity document to review, and Dr. Foster suggested that the timeframe for the observed injuries for the infants involved in the 2023 Cases could be larger than Dr. Reece originally believed. HDH, by counsel, rejected Dr. Foster's opinion that the timeframe was larger than Dr. Reece believed. Dr. Foster recommended expansion of the Windows of Opportunity timeframe, which meant that more suspects were identified.

As investigation continued, Sgt. Fitzer and Ms. Wilson learned that in addition to Dr. Reece, there was another radiologist, Daniel Gardiner, MD, whose opinion concurred with Dr. Reece that the observed injuries in the 2023 cases were inflicted and not accidental. Sgt. Fitzer and Ms. Wilson also learned that Chad Aarons, MD, a pediatric orthopedist, had been consulted before HDH notified CPS of the 2023 Cases, and Dr. Aarons expressed concerns that the observed injuries were non-accidental in nature because of the nature of the fractures.

The 2023 Joint Investigation continued with additional interviews of other family members. Sgt. Fitzer and Ms. Wilson learned that during the course of HDH's discovery of the 2023 Cases, representatives from HDH told various family members of the 2023 Cases victims that HDH was unlikely to learn who was at fault for the various injuries unless someone admitted to them. This was, at least in part, because none of the 2023 Cases victims were under any type of video surveillance in the NICU.

As part of the 2023 Joint Investigation, on October 30, 2023, a series of interviews of hospital employees and physicians who were not employed by HDH but who work for practices that work there were conducted. Dr. Gardiner, a radiologist, told Sgt. Fitzer and Ms. Wilson that he was concerned for non-accidental trauma, and that he had never seen anything like what he observed on the films before. Dr. Gardiner confirmed that the fractures were real and highly suspicious for non-accidental trauma. The basis for Dr. Gardiner's opinion was that whenever

there is an immobile infant who has a metaphyseal corner fracture, that is indicative of non-accidental trauma unless there is an offered history of some kind of shearing injury, and there were no such offered histories for any of the injured infants. Dr. Gardiner also offered the opinion that he had been taught in residency that the observed injuries are "classically from force at the growth plate…like, when a child is shaken." He also opined that if there was a small NICU baby involved, those children would not require as much force to injure. Dr. Gardiner had never seen a pattern or cluster of injuries like this in his career. Dr. Gardiner also told Sgt. Fitzer and Ms. Wilson that he did not believe that his role required him to make a report to CPS. He believed that HDH's upper management would inform CPS appropriately. Dr. Gardiner had not received any training on CPS reporting requirements.

Dr. John Kuta, another reviewing radiologist, told Sgt. Fitzer and Ms. Wilson that the observed injuries in the 2023 cases were not normal and raised concern for non-accidental trauma. Dr. Kuta described the fractures as "unusual" in part because he observed bucket fractures, which he described as commonly being caused when a child fell off the stairs. He was concerned about these injuries and their association with non-accidental trauma because, as he put it, the babies had never left the hospital. He had never in his career seen a child who has never been out of the hospital with this kind of injury. He also told Sgt. Fitzer and Ms. Wilson that he had seen fractures that were concerning for non-accidental trauma, but never in the context of hospitalized NICU infants and never in the context of a cluster of victim children. His understanding of the policy for CPS notification was that the neonatologists were responsible for CPS notification.

Strotman was interviewed as part of the 2023 Joint Investigation. She did not appear anxious or concerned: she was "casual and laid-back". She was represented by a lawyer provided to her by HDH. At the time of the 2023 interview, she had been employed as a nurse for about

four years, with one year of experience in the NICU. She outlined her responsibilities, told Sgt. Fitzer and Ms. Wilson that she had never noticed injury to the involved infants, but that she knew about the 2023 Cases. She had not seen any concerning behavior and disclaimed intentional or accidental injury to the 2023 Cases victims. In the NICU, Strotman would be assigned to specific babies, but that all of the nurses would help each other out, so it wouldn't be unusual for nurses who were not assigned to specific babies to be in and out of individual rooms. Strotman did not say or do anything during this interview that caused Sgt. Fitzer or Ms. Wilson to be concerned: her demeanor was unremarkable.

Another nurse was also interviewed. This person, a nurse with over 20 years of experience, was also on administrative leave as a result of CPS intervention. She denied knowing the protocol for notifying CPS in the event of suspected abuse.

Sgt. Fitzer and Ms. Wilson had two primary suspects: Strotman and the other nurse placed on administrative leave. Sgt. Fitzer and Ms. Wilson developed them as suspects solely because they were the people who had the most contact with the 2023 Cases victims. Despite investigation, Sgt. Fitzer and Ms. Wilson were not able to develop probable cause to arrest with respect to either of these two suspects during the 2023 Joint Investigations.

On October 31, 2023, Sgt. Fitzer and Ms. Wilson then interviewed additional health professionals at HDH. He started with Corinne Balint, MD, who was primarily involved with the injuries observed on Baby M.L. She observed symptoms that concerned her and ordered a skeletal survey that uncovered fractures. She reported her concerns to the Director of Nursing for the NICU, Mandy Winton and informed the mother of the injuries. Dr. Balint's colleague, Arthur Shepard, MD, and Dr. Balint agreed that it was best if the HDH administration "figured out" what happened. Dr. Balint did not report to CPS because she believed it was the job of the HDH social

workers to do that. Throughout his investigation, Sgt. Fitzer and Ms. Wilson found that each witness that they talked to believed it was someone else's job to report the injuries to CPS.

On November 9, 2023, Sgt. Fitzer and Ms. Wilson continued their interviews of health care workers at HDH. Working together, they interviewed Dr. Shephard, Dr. Staples, Dr. Holt, Mandy Winton, Dr. Carra, Todd Zischke, Dr. Singh, Heather Pollard, and Dr. Reece.

First, he interviewed Dr. Shephard, who has 30 years of experience as a neonatologist. Dr. Shephard told him that fractures could occur during the normal course of care in a NICU setting. He also said that he didn't know whether or not what was being observed were even fractures. He remembers discussing the situation with Dr. Balint at the time but was not convinced that the fractures were inflicted injuries. Dr. Shephard was unaware of the protocol for CPS notification. Then Sgt. Fitzer and Ms. Wilson interviewed John Holt, MD. Dr. Holt was concerned about the imaging that he reviewed for two of the babies, but had no concerns about anyone at HDH who provided care to any of the 2023 Cases victims. He did concede that it was unusual for there to be a cluster of injured children with such a highly specific pattern of injury. Dr. Holt did not think the fractures were out of the ordinary but did think the rate and timing were unusual. He didn't report to CPS and instead reported to the hospital administration so they could make appropriate notifications. This interview with Dr. Holt was instructive: it revealed several challenges to determining who might have caused these injuries. First, there were a tremendous number of staff who had contact with these babies. Second, not all these staff contacts were documented or tracked in any meaningful form. Third, HDH and its physicians were unwilling to acknowledge that anyone in HDH's universe could have caused these injuries.

Sara Staples, MD, another neonatologist working in the HDH NICU, didn't have any concerns about the single infant who she observed with a fracture. Significantly, she was

unconcerned about the injury because the child was small.

Mandy Winton was the nursing director at HDH during the relevant period in 2023. She had 14 years of experience in NICU work and had been at HDH's NICU for two years. She had no concerns about the way that staff was treating the 2023 Cases victims, despite the unusual cluster of injuries. She told Sgt. Fitzer and Ms. Wilson that she did not believe any of the injuries were intentional and that fractures can happen during the course of normal care. Despite her lack of concern, she had nevertheless commenced remedial training with all the nurses in the NICU by November 2023. Sgt. Fitzer found that there was investigative significance to the remedial training.

After that interview was complete, Sgt. Fitzer and Ms. Wilson interviewed Heather Pollard, who was the nurse who observed bruising to one of the 2023 Cases victims. She stated that she believed that the bruising that she observed (which was related to a fracture) could have been caused during a diaper change. When she noticed the bruising, she notified her supervisor but did not notify CPS. She said that she had never notified CPS before.

Dr. Carra, a radiologist who practices at various hospitals in the greater Richmond area was contacted by Dr. Balint to review concerning films for one child. He identified a fracture on one of the 2023 Cases victims. Dr. Carra stated that because the child was non-mobile, Dr. Carra believed the injury was traumatic and inflicted in nature, and he communicated that to Dr. Balint. Dr. Carra specifically stated that he thought the behavior that caused the fractures was "possibly intentional."

Dr. Reece is an experienced and well-regarded Richmond-area radiologist. He has extensive experience and has been in practice since 1998. He told Sgt. Fitzer that he had never seen anything like the 2023 Cases during the course of his career. He said that he believes there

was a pattern of abuse. He said that infants like this should not have injuries like this because they are not mobile. Dr. Reece also told Dr. Carra that it was likely that the injury was non-accidental. He highlighted the nature of the metaphyseal injuries and the non-accidental nature of the long-bone fractures. A metaphyseal fracture is a bone fracture that occurs in the metaphysis, the wider part of a long bone near the growth plate.

At some point, Dr. Reece was approached by the Chief Medical Officer for the HDH, Dr. Singh. Dr. Reece told Dr. Singh that the injuries were likely inflicted and non-accidental. As part of his dialogue with Dr. Singh, Dr. Reece created his "Windows of Opportunity" document that establishes the timeframe that Dr. Reece believes that the injuries were inflicted in each of the 2023 Cases. To create this document, Dr. Reece went back to each of the films for the victim children and then looked at the stage of healing of the injury to determine the date range for causation of injury. Dr. Reece then used that to create a period of days as a lookback period to see who had exposure to the 2023 Cases victims during that time. The Windows of Opportunity was a necessary investigatory tool because, assuming that HDH is keeping accurate employment records, it was possible for Sgt. Fitzer and Ms. Wilson to figure out who had access to the victim children. Unfortunately, Sgt. Fitzer and Ms. Wilson also realized that limitations on the Windows of Opportunity existed because the NICU permitted other individuals, including nurses not assigned to individual patients, in and out of patient rooms. Of note, Dr. Reece did not think that the observed injuries in the 2023 Cases were caused by nurses starting IV lines, or swaddling infants. Dr. Reece, the best and most experienced of the radiologists who was asked to review these films, was unequivocal: the observed injuries were inflicted and non-accidental in nature. Dr. Reece shared this opinion with HDH administration in a meeting on September 11, 2023, when he told these administrators that he believed that abuse was taking place. Dr. Reece was not asked

to participate in any additional meetings with HDH administration after this, and CPS was not notified by any HDH personnel until about ten days after HDH was informed that Dr. Reece believed that abuse was taking place in the NICU. This interview concluded this portion of the 2023 Joint Investigation.

Sgt. Fitzer and Ms. Wilson were not able to develop probable cause against any individual in 2023 because while the Windows of Opportunity helped narrow down the universe of suspects, there were still too many individuals who could have been responsible. Video cameras would have made a material difference in the 2023 Joint Investigation.

As part of the joint investigation, Ms. Wilson documented the safety planning that continued to be executed at HDH. The safety planning that was first implemented in September 2023 remained in place during the pendency of the CPS investigation. Ms. Wilson also testified that CPS did not have the authority to close HDH's NICU. The only governmental organization that has authority is the Virginia Department of Health.

At the end of the investigation, CPS made a finding of abuse and neglect for the children involved in the 2023 Cases. The case was "Founded, Level 1 for physical abuse." Level 1 is the highest level. CPS could not identify the abuser with specificity because there were too many people handling the babies during the Windows of Opportunity, so the abuser was identified as unknown, but it was identified as an employee of HDH. The reason that it was identified as an employee of HDH was because the victims were non-ambulatory, they had never left the NICU, and that there was no one other than HDH employees who had access to all four babies. CPS cannot sustain a finding of abuse against an entity like HDH; it can only make a finding against an individual or individuals. Once the determination was made that someone in the NICU caused the injuries, that terminated CPS' authority to conduct additional investigation.

HDH, through counsel, requested a meeting to address the finding. They challenged it because one of the children had what HDH described as brittle bone disease. CPS had considered and rejected that explanation because it was reasonable that sophisticated providers of medical care to premature infants would know how to work with children who did not yet have full bone mineralization. CPS declined to revisit its finding. Once the finding was made, Ms. Wilson notified the four victim families of the outcome of the CPS investigation, a notification that was made contemporaneously with a notification from Sgt. Fitzer on April 8, 2024 that there could be no prosecution because investigation had not revealed a single suspect.

Despite the prosecutorial declination, CPS made a finding that, as Sarah Wilson put it, "someone was at fault for causing the injuries to the [2023 Cases] infants, but that someone is just unknown. We were unable to determine who that person was." CPS did identify the abuser as an HDH employee, not a parent, grandparent, or visitor to HDH. At this point, Sgt. Fitzer and Ms. Wilson's investigation was over and the 2023 Joint Investigation was closed. Once the finding of physical abuse was made, CPS could no longer leave a safety plan in place. Despite the termination of safety planning, Strotman was not returned to work in the NICU until September of 2024, nor was the other nurse who had been placed on administrative leave. They were returned to work in September 2024 once they finished required training from HDH.

In November 2024, HDH notified CPS regarding novel concerns of child abuse. Ms. Wilson was no longer a CPS investigator at this point: she had been promoted to supervisor by then. Ms. Wilson did have the most institutional knowledge about the progression of this matter and for this reason, she was asked to work on the November 2024 HDH CPS matter. Ms. Wilson testified that the difference between the 2023 Joint Investigation and the HDH CPS 2024 investigation (the "2024 Joint Investigation") was implementation of the video cameras. She

testified that it was very difficult for her to close the 2023 Joint Investigation without having a "specific person identified as causing the injuries to these vulnerable babies." Ms. Wilson believes that she could have identified an abuser if there had been video cameras in place in 2023. Based on her education, training, and experience, she believes that the pattern of injuries that she observed in the 2023 Joint Investigation was similar to the injury patterns she saw in the 2024 Joint Investigation. Based on what she knows from both investigations, she is 100% sure that Strotman was the abuser in 2023. Ms. Wilson believes that the 2023 Joint Investigation was compromised by HDH conducting its own internal investigation before it notified CPS.

Sgt. Fitzer's file was reopened on January 2, 2025 when Strotman was interviewed in connection with her culpability for a series of child abuse offenses that took place in September through November 2024. Sgt. Fitzer was asked to participate in interviewing Strotman. Post-Miranda, when questioned by Sgt. Fitzer, she was questioned about her treatment of infants in the NICU and she conceded that she was too rough. Sgt. Fitzer also asked Strotman if the level and standard of care that he observed her providing in a concerning series of 2024 videos was the same level and standard of care that she provided to all the babies she cared for, including the 2023 Cases babies, and her reply was yes.

Sgt. Fitzer stated that the common element that the 2023 Cases victims and the victims from the 2024 cases (the "2024 Cases") was Strotman. Sgt. Fitzer's involvement with the 2024 Cases was limited to his interview of her on the evening of January 2, 2025.

Exhibit B: Summary of Testimony from Elizabeth Scholla, Henrico County Child Protective Services: February 21, 2025 and February 28, 2025

Elizabeth Scholla testified after Sarah Wilson on February 21, 2025 and then again on February 28, 2025. At the time that she testified, she was employed as the Division Manager of the Protection and Prevention Programs for Henrico Social Services, with supervision responsibility for five units. She has her master's degree in social work and her entire career has been in Child Protective Services. At the time of the 2023 Joint Investigation, she was a CPS supervisor. Exhibits 5 through 23, a series of emails and Safety Plans were also offered. Ms. Scholla was responsible for managing the CPS investigative response to the 2023 Joint Investigation and the 2024 Joint Investigation. The Special Grand Jury found her testimony credible.

Ms. Scholla outlined the varying requirements for abuse and neglect investigations under the Code of Virginia. She articulated the different standards for investigations and findings and the variance in the roles CPS and law enforcement, in this case HCPD. She testified that CPS can make an abuse/neglect finding against an unknown person, whereas HCPD cannot bring criminal charges without an identified defendant. Findings against unknown persons are made so that if something happens in the future, it can be referenced again and that children in the community can be protected. A good example of the success of the CPS system is the Strotman matter because the pattern and history was well documented. Ms. Scholla believes that Strotman caused the fractures observed in the 2023 Cases.

Ms. Scholla was the CPS supervisor at the commencement of the 2023 Cases. She explained that there are criteria for CPS involvement in a case: the abuser must be a caretaker, the child must be under the age of 18, and that Henrico CPS had to have jurisdiction, meaning that the child has to reside in Henrico County or that it had to have happened in Henrico. Ms. Scholla

explained that Henrico manages a high volume of CPS reports which are initially screened by an intake worker and are then assigned to various senior workers. In her role as a CPS supervisor, she's required to review more complicated matters where there may be some questions about the steps that CPS should take. It was in the context and in this role that Ms. Scholla first began her involvement with the 2023 Joint Investigation.

Ms. Scholla's first awareness related to the 2023 Cases is documented in an email between her and the Intake Supervisor, Kenya Burton on Thursday, September 7, 2023, after a maternal grandmother of one of the 2023 victim children called in a concern on Wednesday, September 6, 2023 for physical abuse (the "September 6, 2023 Report"). Notably, this was two (2) weeks before HDH alerted CPS that there was a potential problem. The grandmother-reporter called to say that the identified victim child had a tibial fracture. In response, CPS reached out to HDH for more information and left a message with Corinne Balint, MD to try to obtain additional information. CPS was authorized to reach out to Dr. Balint because there is a code section that permits CPS to call any mandatory reporter to disclose that CPS knows about the situation and to request additional information to determine if CPS intervention is appropriate or required and Dr. Balint is a mandatory reporter under the Code of Virginia.

The September 6, 2023 Report is significant because of the timing, which was far before the reporting from HDH. It is also significant because it was considered a "screen-out" report for CPS, which means that CPS did not elect to investigate. Significantly, because screened-out reports are purged after a year, in November 2024, when the 2024 Joint Investigation commenced, the documentation from the September 6, 2023 Report had been purged from CPS' system.

CPS gleaned information from Dr. Balint and Dr. Holt which caused CPS to screen out the September 6, 2023 Report. Ms. Scholla testified that on Thursday, September 7, 2023, Dr. Holt

stated that HDH was unaware of any evidence that suggested that this injury was consistent with abuse or neglect. Because of Dr. Holt's opinion, the matter was closed to CPS, despite the reporting grandmother's best attempts to bring it to the attention of CPS and law enforcement.

HDH failed to provide CPS with information that would have been important: HDH did not disclose that there were additional children in the NICU with concerning fractures. By this time HDH had already retained a law firm based out of Washington, D.C. to conduct an internal investigation. Because information was withheld from CPS, the September 6, 2023 Report was screened out, and no information went to HCPD, so there was no joint CPS/HCPD response to what was going on at HDH prior to September 21, 2023

As previously noted, because of this failure to report and this failure of transparency on September 7, 2023, the September 6, 2023 Report was purged. The only reason that there is any awareness that the September 6, 2023 Report was ever made is because of Ms. Scholla's institutional knowledge and the email chain that exists between her and Ms. Burton that documents, at least partially, what happened. Once a report is screened out, it is screened out and cannot be reopened.

As Sarah Wilson testified, CPS did not realize that there was an issue at HDH for another two weeks. The leadership team of HDH made their referral to CPS on September 21, 2023, a little over two weeks after the reporting grandmother in the September 6, 2023 Report first sounded the alarm. The first person to connect the dots was Kenya Burton, the Intake Supervisor, because the September 6, 2023 Report was factually unusual. Ms. Scholla assigned the September 21, 2023 report made by HDH (the "September 21, 2023 Report") to Sarah Wilson, whose testimony was summarized above.

As the investigators and supervisors in CPS divided what they believed the workload would

be on the 2023 Joint Investigation, Ms. Scholla took primary responsibility for interfacing HDH's counsel. HDH had already led an extensive internal investigation before the September 21, 2023 Report was made. Ms. Scholla believes that HDH understood that there was a problem by Labor Day weekend of 2023. HDH used the time between Labor Day 2023 and the September 21, 2023 Report to investigate and to reach conclusions about the causation of the observed fractures.

Ms. Scholla communicated with HDH regarding CPS' dual mandates of safety planning and investigation. CPS' statutorily mandated requirements are designed to keep victim children safe while joint CPS/law enforcement investigations into allegations of abuse and neglect take place. Ms. Scholla explained the CPS safety planning requirements to HDH repeatedly. She outlined for HDH that after the September 21, 2023 Report, all that existed was an allegation, but that the allegation was so concerning that CPS is required to confirm the safety of involved children and then investigate. CPS is not permitted to investigate without the protection of safety planning for the involved children. Investigation from CPS always conclude with a dispositional analysis: the matter is either founded or unfounded.

In much the same way that CPS does not have the authority to shut down a daycare center, CPS did not have the authority to act to close the entire NICU while the investigation took place. For licensed agencies, like daycares and health care providers, CPS is dependent on its licensing partners to act to close down offending entities.

CPS encountered difficulty in securing information regarding licensure of the NICU from HDH. Ms. Scholla documented that despite repeated requests to HDH, it took over 60 days to learn that information. This was an area of concern for CPS because without a notification to the licensing body, either in the form of a self-report from HDH itself or through a report from CPS, there was no way for the body that licenses the HDH NICU to know that there was an investigation

underway because of concerns for non-accidental trauma. One of the exhibits that was offered showed that HDH, through counsel, finally provided documentation in January 2024 of the person at the Joint Commission (the organization that licenses NICUs) that HDH said that they had notified in September 2023.

As Ms. Scholla continued to supervise the CPS side of the 2023 Joint Investigation, it became obvious to her that HDH had concerns about Strotman, as evidenced by the fact they had placed her on administrative leave. At the beginning of the 2023 Joint Investigation, the guiding document for the timeline of injury was Dr. Reece's Windows of Opportunity document, coupled with his opinion that the injuries observed to the 2023 victims were consistent with non-accidental trauma. The existence of this document was significant to Ms. Scholla because it was prepared before CPS was ever notified. Ms. Scholla also found significance in the fact that Dr. Reece and Dr. Foster were unified in their shared opinion that the injuries to the 2023 victims were non-accidental.

Ms. Scholla worked closely with Dr. Foster to understand the bases for her opinion that the injuries to the victim children for the 2023 Cases were inflicted and non-accidental. Dr. Foster communicated to Ms. Scholla that it was her opinion that these injuries did not come from typical handling for three reasons. First, the affected infants had never been out of the NICU, where they received very specialized care from highly trained professionals. Second, they were completely non-ambulatory. Third, an analysis of their labs did not support an explanation that these fractures came from typical handling.

The 2023 Joint Investigation revealed that HDH's pattern and practice of staffing the NICU made it almost impossible to develop suspects. By the time the 2023 Joint Investigation began, HDH had already placed Strotman on administrative leave. The 2023 Joint Investigation, relying

on a slightly larger Windows of Opportunity timeframe provided by Dr. Foster, revealed that there was another nurse who had contact with the victim children during concerning time periods who had not been placed on administrative leave during the course of the HDH internal investigation and was not placed on such leave until CPS instructed HDH to do so. Moreover, the work schedules and the card swipes documentation were inadequate to establish which individuals were caring for which infants because the team system that was being used had nurses who were not assigned to patients helping provide patient care. Moreover, HDH was eventually cited by Virginia Department of Health ("VDH") because there was no documentation of which nurses were doing sticks or medical procedures. In short, the 2023 Joint Investigation revealed that there was literally no way to know who was in and out of the individual patient rooms.

The placement of Strotman on administrative leave after a private HDH investigation before CPS notification demonstrated HDH's lack of safety planning for the victims of the 2023 Cases. First, HDH placed Strotman on leave but not another nurse who had the same amount of contact with the 2023 victims as Strotman. Their offered explanation for the placement of one employee and not the other was that Strotman was a relatively new nurse and that the other nurse had decades of experience. This logic is inconsistent with an appropriate safety planning approach to victim safety. Nevertheless, the 2023 Joint Investigation did reveal that all the fractures in 2023 did predate the time that Strotman was placed on administrative leave. Once Strotman was placed on administrative leave, there were no more fractures. In fact, there were no new fractures reported until November 2024.

As part of the 2024 Joint Investigation, after the discovery of the concerning video footage of Strotman, Ms. Scholla questioned HDH's representatives directly as to whether there was any additional reason for suspicion of Strotman in 2023. Ms. Scholla specifically asked if there had

been any reasons that HDH had been additionally suspicious of Strotman. Representatives from HDH repeatedly assured Ms. Scholla that HDH only placed Strotman on leave in 2023 because she had not been a nurse for very long. Ms. Scholla did not believe that she was given the full results of the internal investigation. She also believes that the six (6) weeks that it took HDH to contact CPS in 2023 (the time between the onset of the first fracture and the September 21, 2023, Report) was destructive to the 2023 Joint Investigation.

As the 2023 Joint Investigation continued, another problematic issue related to scheduling of employees was the scheduling for the respiratory therapists. As the 2023 Joint Investigation attempted to determine which employees had access to the victim children, it became obvious that some of the respiratory therapists had access to all the victim children during the Windows of Opportunity. When the September 21, 2023 Report was made, HDH had utterly failed to place a single respiratory therapist on administrative leave. When asked by the 2023 Investigators what the rationale for keeping the respiratory therapy team at work was, HDH had two reasons: first, the respiratory therapists don't provide direct nursing care, and second, there were not a lot of respiratory therapists for the NICU and placing them on leave would have had the practical effect of shutting the NICU down, which HDH did not want to do.

Ms. Scholla was concerned about completing the investigation inside of the statutory framework articulated by the Code of Virginia. Even though CPS was partnered with HCPD, the Code nevertheless mandates that CPS have its investigation complete by 90 days after the initial complaint. This was problematic because the completion deadline changes the contours of the continued implementation of safety planning. In this case, there was literally no way to compel HDH to continue the safety planning that CPS put in place past the 90 days.

As the investigation continued, it became obvious to Ms. Scholla that Dr. Foster and Dr.

Reece's opinions were basically aligned. They agreed that the observed fractures were inflicted, non-accidental injuries and that there was period in which the injuries were inflicted (although Dr. Foster thought that the period was larger than Dr. Reece did). It also became obvious to Ms. Scholla that HDH sought to limit the Windows of Opportunity to as short a window as possible. The 2023 Joint Investigation relied heavily on the opinions of both Drs. Foster and Reece as it moved through its work. Additionally, the 2023 Joint Investigation relied heavily on the opinion that even victim children who were unusually susceptible to broken bones were entitled to investigation as to the cause of those fractures.

In explaining the position of the CPS throughout the 2023 Joint Investigation, Ms. Scholla stated that part of the rationale for the finding of abuse was that there were three babies with evidence of non-accidental trauma with no reported history of bone density disorder and a fourth baby in the cluster with a reported history of brittle bone type disease and unexplained fractures. As Ms. Scholla pointed out, "Baby No. 4, who is in the same NICU, in the same time frame, also has a medical condition that makes him more vulnerable. It does not mean that he is…immune from being abuse or neglected. It means that he's more vulnerable to abuse and neglect. And in the area of Child Protective Services where we have to look at [if] we have a preponderance that it's more likely than not of evidence to indicate that this child is the victim of abuse, [CPS] felt very strongly in the context of the totality that baby No. 4 was a victim of abuse. And we made that determination."

As CPS continued to work through the issues that were presented by the delay in notification by HDH, as well as the scheduling irregularities and the safety planning concerns, CPS attempted to implement strategies to safety plan. Strotman had already been placed on administrative leave by the hospital, so she was not having any direct contact with any NICU

patients. The second nurse who was identified as having access to the victim children in the 2023 Cases was also placed on administrative leave after CPS engaged in safety planning that precluded her from having access to the victim children. The 2023 Joint Investigation also identified four (4) total respiratory therapists who had access to all the victim children during the Windows of Opportunity. Because the respiratory therapists' contact with the victims of the 2023 Cases could have been the genesis of the fractures, a "buddy system" was implemented so the respiratory therapists were never left unsupervised with the NICU patients during the safety planning period.

Ms. Scholla testified that the 2023 Joint Investigation team found it "strange" that Strotman was the only person placed on administrative leave by HDH. The team also found it odd that when pressed, that the only reason they gave was that she was a "new" nurse, when a veteran who had the same amount of exposure to the victim children was not judged by HDH to be a concern.

Ms. Scholla also documented an additional concern about HDH's response: while their own in-house radiologist, Dr. Reece, was expressing concern for non-accidental trauma, HDH never consulted with or retained the services of a Child Abuse Medicine Physician, despite the fact that Virginia has two of them close by, one at VCU and one at the University of Virginia ("UVA"). Despite the concerning opinions and the Windows of Opportunity document, the first time that a Child Abuse Medicine Physician was consulted on these matters was October 2023.

Ms. Scholla also testified about her concerns for the HDH NICU in 2023 because the closed the CPS side of the 2023 Joint Investigation. She was concerned that HDH's leadership was not taking the allegations of abuse seriously. She was also concerned that the HDH leadership team was taking a position contrary to the position of its own radiologist and of Dr. Foster, who was the board-certified Child Abuse Medicine physician, who were aligned in their concern. Ms. Scholla testified that HDH seemed focused on terminating the buddy system as quickly as possible.

Additionally, she commented that the Department of Social Services was clear in its response to HDH: Social Services was not releasing HDH from safety planning, it just no longer had the statutory authority to enforce the safety planning. Ms. Scholla was unequivocal: "[t]here's a very important distinction there to say the Department of Social Services is not giving the hospital its blessing and saying, oh, you're assessed to be safe. We are saying we have concerns. You have worked with us, and we are now at the point where we no longer have the authority to enforce you to continue to do what we asked you to." Put differently, Ms. Scholla recognized that the Department of Social Services had reached the outer limits of its enforcement authority and that despite what she perceived as HDH's dismissive approach to her concerns, the statutory authority to enforce safety planning ended after the finding was made. Ms. Scholla was never happy about the safeguards for infants in the NICU at HDH. Ms. Scholla commented that at the end of the 2023 Joint Investigation, CPS believed that the cause of the fractures was "non-accidental trauma, but [CPS] did not know who caused them. And [CPS] did not have significant evidence going in any direction. There were no videos; staff logs were confusing. [CPS] didn't have a good idea of exactly when anything happened. So [CPS] was not even in much of a better position right then than we were probably about a month into the case in knowing who caused the injuries. [The 2023 Joint Investigators] had narrowed it down to say respiratory therapists and the two nurses were the ones who had the most access to all of the babies altogether, but we did not have any different information to identify who would cause the fractures."

By December 2023, steps were being taken to end the investigation and move forward with resolutions, a timeline that was driven by CPS timeline mandates. Additionally, HDH was requesting permission from the 2023 Joint Investigators to resume its internal investigation. Ms. Scholla believed that HDH wanted to finalize its investigation so that it could return those on

administrative leave to work and end the buddy system that was still in place for the respiratory therapists. Moreover, Ms. Scholla testified that, in 2023, one of the continuing open questions that CPS still had was whether there would be any criminal charges as a result of the investigation.

Ms. Scholla testified that at the end of the 2023 Joint Investigation, while there were several individuals who had had access to all four of the victim children during Dr. Reece and Foster's Windows of Opportunity (including Strotman), no single suspect could be developed. Under the Code of Virginia, there is a non-jailable offense of failure to report concerns of child abuse to CPS, and this charge was considered for various HDH employees. According to Ms. Scholla, the difficulty with the failure to report charge was that "the information was touched by so many different people in the hospital who were mandated reporters and worked their way up the chain. And there were so many failings at the institutional level, to pinpoint one individual to say they were responsible for it was incredibly challenging and difficult." After thoughtful review, HDH and the Commonwealth's Attorney's Office entered into an agreement that called for employee training around child abuse and mandatory reporting requirements. HDH also took the affirmative step of installing security cameras in each of the patient rooms in the NICU so that patient care could be recorded as part of HDH's agreement with the Commonwealth's Attorney's Office for non-prosecution for the failure to report to CPS charges.

On December 20, 2023, the Safety Plan period for the 2023 Joint Investigation ended. HDH was aware that it ended and confirmed that it was over via email that same day. Ms. Scholla's concerns about the children in the NICU continued unabated. Her concerns were heightened because during the 2023 Joint Investigation, several doctors commented that NICU babies just get fractures. This was a position that was also advanced during the 2023 Joint Investigation by HDH's counsel. Ms. Scholla expressed that this case weighed on her because of the

disappointment that she felt that the 2023 Joint Investigation was unable to identify who had caused the injuries.

After the 2023 Level 1 finding that identified the abuser as an "unknown hospital employee", HDH pressed back, contacting the State Department of Social Services. This complaint was then communicated to the Director of the Henrico Department of Social Services ("DSS") and then back to Ms. Scholla. HDH's stated concern was that they had no appellate avenue. Despite the pressure from HDH, the finding was not amended or set aside. This concluded Ms. Scholla's involvement in the 2023 Joint Investigation.

Unfortunately, the HDH NICU investigations did not end in 2023. On November 22, 2024, a CPS report came in from HDH's NICU that there is an unexplained fracture in a NICU baby. Ms. Scholla commented that the immediate report demonstrated that the education component of the resolution of the 2023 matters was effective because the report was made within four hours of the discovery of the injury.

Safety planning was implemented immediately on November 22, 2024. Because of the immediate reporting, Ms. Scholla felt on much firmer footing and believed that CPS could do a better job addressing the immediate safety concerns presented by the new report. A new CPS investigator, Rochelle Burrell was sent to commence investigation because Sarah Wilson had been promoted. Even though Ms. Scholla had also been promoted, she nevertheless assigned herself to supervise this matter because she had so much institutional knowledge that she gained during the 2023 Joint Investigation.

Ms. Scholla immediately started gathering resources in anticipation of a joint investigation with law enforcement (the "2024 Joint Investigation"). Her first call was to Dr. Foster to coordinate consultations. Because of the swelling, Dr. Foster initially believed that the injury was

acute and had to have happened within the past 24-48 hours. Additionally, because of lessons learned during the 2023 Joint Investigation, Ms. Scholla also immediately called VDH because Ms. Scholla knew that was the only entity with the authority to take a licensure action against the NICU. As a result, VDH immediately commenced investigation. As a result of this process, VDH eventually placed the NICU into a State of Immediate Jeopardy, which is a serious finding because it implicates federal and local funding for Medicaid and Medicare. As part of the 2024 Joint Investigation process, and because of the involvement of VDH and the finding of Immediate Jeopardy, the HDH NICU voluntarily halted admissions into the NICU for a short period of time. These licensure actions were designed for patient protection.

The first victim in the 2024 Joint Investigation was a child who had multiple fractures. The investigatory process was still the same, although Ms. Burrell was now the CPS investigator and Megan Lynch was the detective from HCPD's Special Victims Unit because Sgt. Fitzer had been promoted. Very quickly, Dr. Foster offered an opinion that the observed injury on this first baby was inconsistent with accidental trauma and consistent with inflicted injury. After she reviewed the imaging of the injury, Dr. Foster amended her opinion as to the age of the injury as she concluded that the injury was non-acute.

Strotman and the additional nurse who was placed on administrative leave in 2023 were permitted to return to the HDH NICU after they received the training that HDH agreed to as the resolution of the 2023 Joint Investigation. These two nurses were placed back on administrative leave on November 23, 2024. HDH did not inform the 2024 Joint Investigators that HDH had taken that employment action, despite the fact that neither Strotman or the other nurse had been returned to work until September 2024 after completion of the education requirements set forth in the agreement with the Commonwealth's Attorney's Office. While Strotman was out of work,

there were no infants who were the victims of any non-accidental fractures.

The next 2024 Joint Investigation victim was reported to CPS on December 18, 2024. When Ms. Scholla received this report, she was again concerned about the size and scope of what she perceived to be a reoccurring problem at HDH's NICU. The report was made to CPS by Dr. Shepard. Baby No. 2 was initially incorrectly reported to have metabolic bone disease.

By the time that the report for Baby No. 2 was made, CPS already had the investigation for Baby No. 1 well on its way. Because of the narrow window of opportunity for Baby No. 1 initially provided by Dr. Foster, CPS was initially quite optimistic that a suspect would be developed quickly by a review of the video camera footage that was now available. Unfortunately, as Dr. Foster reviewed the films, she realized that the injury was not acute, as originally believed, so the window of opportunity for the offense was going to be much larger than initially hoped.

As investigation commenced, the 2024 Joint Investigators quickly realized that the video footage, while helpful, had limitations. Specifically, HDH had inserted large black digital boxes on large sections of the video footage. The stated reason for the placement of the black boxes was to cover the chairs where nursing mothers might sit to nurse a baby. The digital black boxes could not be removed and the covered video could not be recovered. After a request from the 2024 Joint Investigators, the black boxes were removed. An additional issue regarding the video was developed, as well: while the video cameras were recording everything, no personnel was assigned to conduct a contemporaneous review of the security cameras: no one at HDH was watching the video that had been installed.

When the 2024 Joint Investigators responded to HDH on December 18, 2024 because of the report for Baby No. 2, they discovered that HDH was out of compliance with the safety plan that was put in place on December 2, 2024. The December 2, 2024 safety plan was put in place to

expand the initial 2024 safety plan which was implemented on November 22, 2024. The reason for the December 2, 2024 amendment was that HDH asserted that it was an undue burden on it to keep all of the treating professionals, including physicians, out of their roles, so the safety plan was amended to permit supervised contact, but because of the broader window of opportunity for Baby No. 1 and the continuation of concern, it was to include all the staff who were treating all the babies. On December 18, 2024, Investigator Burrell observed that HDH was out of compliance with the December 2, 2024 safety plan. Instead of implementing an observer program for all staff, they had implemented an observer program for the staff who were in what was the initial window of opportunity timeframe of 48 hours that was initially offered and later amended by Dr. Foster. This was a materially different implementation of the December 2, 2024 safety plan and did not comport with the parameters of the December 2, 2024 safety plan.

This information was reported by Investigator Burrell to Ms. Scholla, who continued to be chiefly responsible for this matter. If this case had been an in-home case and Ms. Scholla had been confronted with this safety plan violation, she would have sought a court order and removed the affected infants from a home where the violating adults were located. Because of the nature of this case, she did not have the authority to remove the children from the hospital, so she contacted her colleague at VDH, Kimberly Beazley. In response to Ms. Scholla, Ms. Beazley sent an investigator from VDH, Mary Torrieri.

As Investigator Burrell and Investigator Torrieri worked on their investigation and as Investigator Burrell tried to implement a safety plan in the context of the concerning injuries to Baby No. 2, HDH did not want to agree to follow the December 2, 2024 safety plan as written. HDH wanted to have 24 hours to implement the December 2, 2024 safety plan as written and Ms. Scholla would not agree to that. By 5:30pm on December 18, 2024, HDH was on a conference

call with Ms. Scholla trying to iron out a safety plan that was less restrictive than the plan that Ms. Scholla wanted to implement. HDH's senior leadership team, including Ryan Jensen, the CEO for HDH, was on this call. During this call, HDH put a neonatologist on the call to offer the opinion that fractures spontaneously occur in NICU infants, but this physician did not offer that opinion. To the contrary, this physician said that he had not had the opportunity to review the case history of Baby No. 1 or Baby No. 2, and he recommended that HDH implement any safety measures that Ms. Scholla was compelling on the part of CPS.

At this point, HDH agreed to the requirements of the December 2, 2024 safety plan. Ms. Scholla testified that she was willing to offer suggestions for ways that HDH could overcome the barriers to implementation that HDH stated that it had. Specifically, HDH claimed that it did not have enough manpower to have observers for all the staff. Ms. Scholla suggested that someone could watch all the live video footage or that family members of the NICU infants could be used as observers. According to Ms. Scholla, HDH did not like her suggestions but eventually implemented them. All in all, HDH was out of compliance with CPS' December 2, 2024 safety plan between December 2, 2024 and December 18, 2024. If the injuries to Baby No. 2 had not been reported, CPS would never have known that HDH was out of compliance with the plan that HDH itself was a signatory.

Ms. Scholla also noted that investigation eventually identified Strotman as the sole offender on all of the 2024 victims. HDH placed Strotman on administrative leave on November 23, 2024, the day after it became aware of injuries to Baby No. 1. Strotman was not working at HDH during the period of time that HDH was out of compliance with the December 2, 2024 safety plan.

Dr. Foster was immediately consulted on the injuries observed on Baby No. 2. It was Dr. Foster's opinion after a comprehensive review that this baby's injuries were non-accidental and

inflicted. As Dr. Foster developed her opinions, the 2024 Joint Investigators realized that all the injuries happened before November 23, 2024, even though the discovery of those injuries did not take place until later.

As investigation and review of the video continued for Baby No. 1 and Baby No. 2 into late December 2024, HDH made an additional report to CPS for Baby No. 3 on December 24, 2024. An on-call worker responded to HDH and made contact with this baby and his parents.

Strotman's employment history was examined by the 2024 Joint Investigators. Strotman was placed on administrative leave in September 2023. She was placed back on the schedule on September 2024. She was required to complete four shifts with a preceptor but then she was released to unsupervised contact with patients in September 2024.

As the 2024 Joint Investigation marched forward, various investigators from various agencies reviewed hours and hours of video footage of Babies No. 1, No. 2, and No. 3. Review of the video showed very concerning treatment by Strotman of Baby No. 1 and No. 2, treatment that would have immediately been questioned if it had been viewed contemporaneously by reviewing nurse or nurse-supervisor. Because of Strotman's behavior, the 2024 Joint Investigators also requested all video footage of any patient room that she entered from the time she was returned to work in September 2024 until she was placed back on administrative leave in November 2024. Review of all the Strotman videos revealed an additional child, Baby No. 4, who was the victim of care that was so gross or negligent as to constitute an additional crime.

Exhibit C: HDH's training video: February 28, 2025

The Special Grand Jurors reviewed the training video that was prepared by Nancy Oglesby, who is the Juvenile & Domestic Relations Specialty Prosecutor for the Commonwealth's Attorneys' Services Counsel, in conjunction with Henrico County Department of Social Services Director Gretchen Brown and Child Abuse Medicine Physician Robin L. Foster, MD.

This video was prepared as part of an agreement between the Henrico County Commonwealth's Attorney's Office and HDH. It outlines the mechanism of inflicted injury and the requirements of reporting for mandatory reporters. All personnel who worked with the NICU babies were required to view it. Strotman viewed it before she was returned to work in the NICU in September 2024. HDH also placed video recording equipment in each patient room after the 2023 Joint Investigation.

Exhibit D: Detective Megan Lynch, Detective: Special Victims' Unit for Henrico Police Division: March 7, 14, and 21, 2025

Detective Lynch is a detective in HCPD's Special Victims' Unit. She has been employed by HCPD for a total of nine and a half years. She worked in the Patrol Division for about the first six years of her career and then pivoted to work with special victims. She holds her bachelor's degree in criminal justice from VCU. She was the assigned HCPD detective in the 2024 Joint Investigation. Sgt. Fitzer was not assigned because he had been promoted from a detective role in SVU to a patrol sergeant role. Det. Lynch did not have any role in the 2023 Joint Investigation and did not have any specialized information about it at the time that she was assigned to the 2024 Joint Investigation. Exhibits 24 through 57 were also offered through this witness. The Special Grand Jury found her testimony credible.

Det. Lynch's involvement in this matter began in November 2024 when she received the CPS alert that was generated once CPS received and validated the call it received about Baby No. 1. Det. Lynch responded to HDH and met with the CPS Investigator Burrell. Det. Lynch commenced investigation by introducing herself to Baby No. 1.'s family in the room where he was being treated. She noticed the presence of video cameras almost immediately, which she described as being "fantastic" from an investigatory point of view and she was optimistic that having video evidence would help her develop a suspect or suspects.

Det. Lynch outlined the types of cameras that were being used in the room. The first were cameras that are installed in the ceiling. They are sophisticated surveillance systems: the resolution is excellent and they record what is happening in the room continuously. The footage that is generated can be reviewed with a player that allows the viewer to zoom in and control viewing. This video was of high value to an investigation. The second system, which is called "Angel Eyes" was designed to let parents observe their children when parents could not be physically present at

HDH. It is of no investigative value because it does not record; rather, its function was to let parents see their child in real time. Additionally, because of HIPAA regulations, the Angel Eyes system is disabled every time a child receives medical care.

During her initial investigation, Det. Lynch reviewed Sgt. Fitzer's file from 2023. She also requested medical records and imaging for Baby No. 1, and she collected staff schedules. After review of Fitzer's file, Strotman was immediately interesting to Det. Lynch because of Strotman's 2023 disclosure that she had been placed on administrative leave. Det. Lynch also considered this information because her initial review of the staff schedules demonstrated that Strotman was a person of concern in 2024 because she had access to Baby No. 1 during what Dr. Foster quickly developed as the window of opportunity for harm.

On November 22, 2024 when Det. Lynch went to HDH and met with HDH personnel, no one told her that Strotman had already been placed on administrative leave. HDH also did not tell Det. Lynch that Strotman was required to work four shifts with a preceptor before she was permitted to return to work. HDH did not tell Det. Lynch that Strotman was the only person who was required to have shifts with a preceptor prior to returning to the NICU. Det. Lynch did know that Strotman stayed on administrative leave until she received training that was required by the Commonwealth's Attorney's Office in September 2024.

Det. Lynch, working with CPS Investigator Burrell, began to develop her investigative strategy to successfully quarterback the 2024 Joint Investigation. She coordinated efforts to review video footage, interview witnesses, and get opinions from experts as to injury causation for Baby No. 1. Part of the challenge in this investigation was that Dr. Foster initially thought that the swelling established a timeline of 24-48 hours, but as her review of the medical records and imaging was completed, she determined that the injury was likely appreciably older. In fact, by

the time that Dr. Foster had completed her analysis, Det. Lynch had to backtrack into early October 2024 for timeline on Baby No. 1's injury. On one hand, the 2024 Joint Investigation was operating from a position of strength because there was a timeline and there was video footage to review. On the other hand, the number of hours of video that had to be reviewed was massive. Det. Lynch quickly developed a protocol for reviewing the video but it was slow going.

Unfortunately, as previously noted, the video had limitations: the recording had two large black boxes on the screen that could not be removed. They were placed there to cover what were called the "nursing chairs" and were placed on the video for privacy for nursing mothers. Nothing behind the black boxes could be seen, nor can the video behind the black boxes be recovered.

Det. Lynch was working when the December 17, 2024 call for Baby No. 2 came from CPS. She immediately assigned it to herself. Baby No. 2 was preparing for discharge when a series of diffuse fractures were discovered. At this point, Det. Lynch, who was working on video review of Baby No. 1's matter, immediately requested six weeks of video so that HDH could start to prepare it for her. Dr. Foster was consulted almost immediately and after review, she offered the opinion that the observed injuries were non-accidental, even though HDH was advancing metabolic bone disease as a reason for the observed injuries to Baby No. 2.

On December 24, 2024, another case alert cames in for Baby No. 3. Baby No. 3 had a single, healing rib fracture. The offered history was that Baby No. 3 had periods of apnea requiring intervention, and that this child had a history significant for one instance of stimulation so vigorous as to cause the fracture. Dr. Foster was asked to review the imaging and concluded that it was non-accidental in nature.

Because of overwhelming concern about patient safety, the VDH became involved in this matter as a result of the 2024 Joint Investigation. In late December, pursuant to a voluntary

agreement between VDH and HDH, HDH agreed to cease new intakes in their NICU and to offer transfer of care to different facilities. By this point, many different agencies were being recruited to provide investigative support to the 2024 Joint Investigators. HDH was interested in identifying the perpetrator, not only because of the injured children, but because they had many out-of-work nurses and other professionals because the NICU was not taking new admissions. HDH began to have its nurses who were not able to work in the NICU because of the reduced census of patients review the videos, as well. While the 2024 Joint Investigators could not stop HDH from having the out-of-work NICU nurses review the video footage, the 2024 Joint Investigators were uncomfortable with the obvious conflict of interest presented by this situation. For this reason, the 2024 Joint Investigators did not rely on the work performed by the HDH employees tasked with reviewing the video.

Finally, the 2024 Joint Investigators found the needle in haystack they were searching the video to find. One of the HCPD officers who was assigned to review the video found a concerning encounter between Baby No. 1 and a nurse. When discovered, it was immediately obvious to Det. Lynch that the demonstrated behavior was short of the accepted standard of nursing care. The 2024 Joint Investigators did not know who this nurse was. It was, of course, as they discovered later, Strotman.

At virtually the same time, the 2024 Joint Investigators received a communication from counsel for HDH that their reviewing nurses had discovered a concerning video of treatment of Baby No. 1 by one of the HDH NICU nurses. This nurse was also Strotman.

This concerning video was shown to Dr. Foster on December 31, 2024. Dr. Foster had not been offered all the videos of all of Baby No. 1's course of care, but based on her review of the video, Dr. Foster was able to offer the opinion that the observed behavior was inconsistent with

the accepted standard of nursing care for a NICU infant. This opinion was ratified by HDH's nurse trainer for the NICU, Lisa James, who was interviewed and offered the opinion that the demonstrated behavior was inconsistent with appropriate nursing care. Ms. James also offered the opinion that the demonstrated behavior in this concerning video was inconsistent with Strotman's education, training, and experience as a HDH NICU nurse. Notably, Dr. Foster was not prepared to offer the opinion that the behavior observed in the video that was provided to her was the behavior that caused the fractures to Baby No. 1 because she was only being shown clips of instances of care, not the child's entire course of care.

As the videos were reviewed, more instances of concerning care were documented, not only of Baby No. 1, but of Baby No. 2, as well. It was also documented that the behavior demonstrated by Strotman was markedly different when she was alone in the room with Baby No. 1 and when there were other individuals in the room with her. It was also documented that Strotman knew that the video cameras were on and recording her behavior. Additionally, when Det. Lynch testified, she had not observed anyone else behave in a way that was inconsistent with accepted standards of nursing care in all the video she watched. Moreover, she testified Strotman's behavior with Baby No. 1 and Baby No. 2 are the only videos that are concerning for abuse.

Detective Lynch commented that while finding the initial videos was quite difficult, once the team figured out who the person of interest was, it became far easier to identify the concerning behaviors. In fact, once the 2024 Joint Investigation team identified Strotman as a person of concern and then pulled all additional video, the team was able to pinpoint concerning behaviors perpetrated on a infant who were fortunate enough not to suffer broken bones who was later identified as Baby No. 4.

Detective Lynch then went on to describe the manner in which the initial arrest of Strotman

was handled. By December 31, 2024, Dr. Foster had been consulted and probable cause had been developed for Strotman's arrest for one charge involving Baby No. 1. Once Strotman was identified as the suspect, she was asked to appear for a voluntary interview; however, because HDH made a decision to terminate her employment, it was decided to arrest her and see if she would agree to make a statement once she was read her rights pursuant to Miranda.

Strotman made an extensive statement and the relevant and probative statements that she made are provided in the section identified below. After she made the statement, she was served with her warrants and processed through the Henrico County Jail. She was held without bond.

Det. Lynch also reviewed Strotman's employment history, and there was nothing particularly unusual in it. Her evaluations were mostly satisfactory, with a few scores that indicated a need for improvement, but nothing that would have caused concern or been perceived as being out of the ordinary. Her employment records showed that her employment at HDH was the first full-time job that she had out of nursing school, which she completed at ECPI. Of note, Strotman did not have her Bachelor's in Nursing, which is the preferred credential for hire at HDH. Instead, she had the minimum competency required for hire. She was scored as a competent employee in 2020, and 2021. HDH noted that a professional goal for her was to enroll in an accredited BSN program by August of 2022, which she did not do. She was current on her professional development and deemed to be competent to supervise LPNs and other aides.

The employment records that were sought and received as part of this investigation also show that Strotman transferred to the NICU on May 15, 2022. Her first evaluation from her supervisor in the NICU was strong. The supervisor commented that Strotman "is a breath of fresh air to our unit. Her positivity is infectious and she is always looking out for her co-workers. She is a natural leader in the unit, and easily takes on precepting new nurses and welcomes them on to

the unit. She is UPC chair and actively works to promote a positive unit culture through giving nurses a voice, recognizing excellence and promoting staff bonding experiences. She also has applied for the clinical ladder."

Additional review of Strotman's employment file shows that shortly after she was returned to work, on October 3, 2024, she completed the class on identifying and reporting suspected child abuse that was required by the Commonwealth's Attorney's Office as part of the agreement that was reached in 2023. (The Commonwealth's Attorney's Office and HDH also agreed to the installation of the video cameras as part of the resolution of the 2023 Joint Investigation matters.) At all times that she was employed by HDH, Strotman was in full compliance with all continuing education requirements that existed for her to work in the NICU. In fact, a large section of her employment record is dedicated to the extensive training curriculum that she received as she transferred to the NICU. As previously noted, she onboarded into the unit in May of 2022 and it appears that she finished all the initial training modules by about September of 2022, at which point, she would have been permitted to provide patient care independently. There is also documentation that she received training on how to appropriately provide neonatal resuscitation, so she would have gotten appropriate education on how to avoid rib fractures. It is obvious that the HDH training protocol for new transfers to the unit is robust and intended to be comprehensive and designed to promote patient safety as the primary goal.

Strotman's hiring process with HDH shows that it happened in the ordinary fashion: she was screened by a company called CareerBuilders that finalized a pre-employment evaluation in June of 2019. Strotman had no criminal record, she had finished her nursing degree at ECPI on May 5, 2019, and her employment experiences were verified. As she was onboarded on May 8, 2019, she agreed she wouldn't use drugs or alcohol and she also agreed that she could be drug or

alcohol tested at any time. She made the necessary attestations that she was eligible to participate as a nurse in federal health care programs. It appears that her initial employment at HDH was through Parallon WorkForce Solutions, although it appears that she became an employee of HDH at some point later in her employment history.

In the Medical History Questionnaire that she completed as part of her employment process, she denied any relevant history of cardiac problems, denied any history of addiction to any drugs, denied any mental health conditions. She denied any history of any hospitalization, psychiatric or otherwise. She denied any health-related reason for not being able to perform the job she was offered.

HDH has documentation of Strotman's licensure status: in 2019 when she was onboarded, her nursing license was in good standing. She did not have any current board actions against her. Her multi-state license was in good standing.

As a new nurse, Strotman was not assigned to the NICU. She was assigned to the Progressive Nursing Care Unit at HDH. This was consistent with the training that she had as she began her career, as NICU positions are generally highly-sought after and the process to get into that unit is generally competitive.

Her employment records show that HDH trained her by requiring her to show that she can perform all of the required competencies. HDH used exactly the same training protocol with Strotman in 2019 that they used with every other new and inexperienced nurse who had just graduated from nursing school. This understanding was confirmed by Det. Lynch when she interviewed Lisa James, who leads nurse training. New nurses are trained the exact same way every time to make sure that they all know how to do their jobs the same way. At HDH, as at other medical institutions, the preceptor program is important: more experienced nurses show new

nurses how to do a job properly.

Det. Lynch also reviewed Strotman's 2024 Ongoing Competency Evaluation for 2024. This document was completed on September 17, 2024. This was the first day that Strotman was back at work after having been placed on administrative leave in September 2023. On September 17, 2024, Strotman's skills, including her competency in Fragile Bone Protocol, are all validated on the date that she comes back to work by Lisa James, the nurse trainer. On September 17, 2024, Strotman proves to HDH's satisfaction that she is competent to treat NICU babies. When her competencies were evaluated on September 8, 2023, which was about the time that she was placed out of work in 2023, they were found to be similarly strong. When questioned about Strotman's competencies in 2022 and 2023, Lisa James had no concerns. As previously noted, in 2022, she successfully completed all facets of the onboarding process into the NICU after having been employed on adult units since 2019. A comprehensive review of her performance evaluations show that there was absolutely no concern on the part of HDH about Strotman.

Strotman did have one Disciplinary/Corrective Action Form in her file, dated April 28, 2023. It was from Sarah Scheer, her supervisor, for a verbal reprimand for tardiness. Strotman had seven tardies in a period of four months between November 2022 and April 2023.

Det. Lynch also reviewed the contents of Erin Strotman's phone. She found a series of text messages between Strotman and her boyfriend that reflected a concerning pattern of disputes between the two of them, particularly during the period that the behavior that did not meet the standards of nursing care were documented on the videos. The text messages also make reference to the use of marijuana and prescription drugs.

Exhibit E: Strotman's confession video: March 14, 2025

As Detective Lynch outlined, Strotman agreed to a post-Miranda interview on January 2, 2025 after her arrest. This interview was conducted at Henrico County's Public Safety Building and was audio and video recorded. Relevant statements made by Strotman are provided below for review. These are all Strotman's verbatim statements and are included in Commonwealth's Exhibit 34.

To describe her employment process to the NICU and the training regimen inside of the NICU, Strotman said:

- "But like I told, I don't remember if I told you or the other officer, but I applied to the NICU three, four years in a row. I think it was the fourth year that I got accepted. Gotcha. Um, they're very, like I said, they're very particular with the people they hire and they have to be, I mean, it's a very, yeah. It's a serious unit. And um, I was very lucky after, um, the fourth try to finally get an interview Yeah. And get a position in there. So I've been there since I think the end of 2022."
- "It was wild world, um, just because, uh, the adults and the babies made it hard, but also the level of acuity made it Yeah. Like difficult in the beginning, just remembering. 'cause you learn all of like the ICU like drugs that you would see, like drips that you would commonly see in the ICU. You learn those in nursing school. But when I worked on the med surg unit, I didn't touch a drip. Oh, I see. Maybe had a heparin drip. Yeah. So I had to like revert back to like nursing school skills to come back into the NICU. Okay. But they've always, I like they way that they train people there. Yeah. They have a fat binder number one that you fill out. And I think now they're trying to get it to where it's on a computer system so that we can just like log in and like, put stuff in the system instead of having to like chase one person around with a binder. Because they'll, if you're training with somebody, you may be with one person one day. You may be with another person another day. You may even like switch in the middle of the day to another person."
- "And they also, for the first I think week that I was in orientation, I did not touch basically anything. It was more of like a watch and observe how we do this and we're gonna talk through how we do these processes. And then like, that's when we went over like safety with like the golden hour babies, which are the under 32 weeks. Like keeping their head midline for 72 hours and not lifting their legs above their head. And like, you know, how obviously it pertains to this, how easy they are for breaks and everything else. Um, so they

try to educate you in the beginning about those kind of things that you should, you know, look out for or be more, you know, concerned with."

- "We normally get a 12 week orientation. Okay. So we get a good like three months, um, that you're with someone and someone is watching your every move, which I, I loved personally because I was like, I want you to tell me if I, you know, if I'm doing anything wrong. Yeah. Like, please, like, inform me so that I cannot not do that. You know? Yeah, yeah. Yeah. Um, so, and then after that, if you or your preceptor, which is the person that is training you. Yeah. If either of y'all feel like, Hey, I'm not comfortable yet, I'm not there yet, they'll add more weeks that you're with somebody. Yeah."

Describing the reason that she became interested in being a NICU nurse, Strotman said:

- "I just, I feel like you have to, I feel like you just have to have a different level of like caring and love like you. Mm-hmm. It's, you have to actually pay attention and you have to look at them and they're so innocent and they're so sweet and they're just like, they're like, they're like the piece of happiness in the world that isn't there right now. Like, with all the shit going on, it is nice to go to work and to snuggle a baby and to feed a baby and to know that you're like, you're making these parents days mm-hmm. And like, you know, Hey, do you wanna hold your baby for the first time? Like, I know that you haven't been able to because they've been really sick, but like, today is the day. Like, do you wanna do it? I just think, I'm not even sure it was like the babies. I think the whole just situation appealed to me after seeing all of the people's stories on Facebook and seeing all of the stuff on social media about just NICU nurses and how resilient they are. And just like, I just wanted to like embody that and be that. And I knew, I have always had kids in our family. I've had cousins growing up that were babies. So I just, they're, they're fun to love on. They're like, like I said, they're the innocence in this world that we don't have anymore."

Strotman agreed that her work could be very overwhelming:

- **"**I feel like some days in the NICU could be overwhelming. But I, I feel like I've spoken to our staff there. Everybody is so involved and has your back. That if you feel even the slightest bit overwhelmed, you may not even realize it. And they'll be like, listen, I'm gonna take this over for you. Go take a break. Like, we take care of each other on that unit."
- **"**I just remind myself that I'm at work. This is my job. These people rely on me. I try not to soak in to the stress of things necessarily because taking on a nursing job in general is stressful. And then taking on a nursing job with one-pound infants is even more stressful. So I feel like going into it, you kind of expect a certain amount of like overwhelming stress. But I feel like I always had someone to go to and be like, Hey, just come and like, just sit and talk with me while I feed my kid. Like just, you know, just like, get my mind off stuff. Come help me do my iv come help me. Even just change these linens on the bed. Like, we're like a, we are those people that like to turn on one person job into like a two, three person job, three preacher at the choir just for fun. I'm like, listen, I don't wanna do this

alone, so I want you to come in there with me. Um, we kinda keep each other sane and entertained is what I like to say."

- "They, it's not even that they are stressful, it's just the events that can happen with them are stressful. Like they're just, uh, not stable most of the time. So not, um, like the, when we get, uh, what we call golden hour, which is under 32 weeks or less. Um, and bring them up to the unit. Normally they're intubated. They may need like, medications for blood pressure. They may need medications to keep their heart rate going up. Um, there's just a lot of like running a, even like a code situation that's like stressful in itself. So I just, I feel like, I don't know, I feel like when you accept a NICU job, you kind of accept that you're gonna have a higher level of stress than some of the other like specialties. Mm-hmm. Because these are people's babies and they are the most vulnerable population because they're, they're the tiniest number one and number two, they can't speak for themselves mm-hmm. At all to tell anybody what anybody's doing."

Strotman acknowledged understanding that NICU babies should not have their feet to be above their heads:

- "That's supposed to be, so they're, they teach you that it's really not the best for the premature babies. Even the ones that have gotten older for their like head or their feet to be above their head like this. Okay. Um, because, you know, a normal term baby, you'd, you'd pick their legs out like this and you'd change their bottom. Yeah. And um, they taught us not to hold like this. Number one."
- "Yes. Um, and it was for intra ventricular hemorrhages. Um, the baby's, the pressure that you're putting up into the baby's like head with blood flow. Having the blood flow come all the way from the legs when they're in the air. Like this can put too much pressure and cause brain bleeds. So we try to for the most part. Okay. Avoid that. But I mean, because some of the bigger babies like we get, we do get term babies, so Yeah. Yeah, yeah. So I do, I know I get it was with the regular. Yeah. So with the regular ones, I, I will, I will just pick them up like a normal, like I would my niece or nephew and change their butt."

Strotman also acknowledged using "bicycling" to try to remove gas from Baby No. 1.

- "During a diaper change? Just like this? Yeah, probably. Yes. 'cause he was very refluxy and gassy. Uhhuh. And this is a common, the bicycles are a common way that we try to relieve gas for them. Okay. So I could, I, I don't remember specifically, but I could definitely probably say that I probably did that."

After being shown video that every professional who viewed it judged to be concerning and not to the minimum standard of nursing care, Strotman stated:

- "Um, I, I feel like it was just my regular care, honestly. I mean, I didn't do anything different or anything that I feel like I would be concerned about."

- “I honestly didn't at the time feel like I was putting all my weight on him. Nothing was going on that day. Okay. And if it, if it looked rough, it was unintentional. Okay. Because I, I do the, I like, if you go back to the other rooms that I've been in too. I do it to the other babies as well. Mm-hmm. And I just, I didn't think that that was rough. Other people have seen me do it. I just, I didn't think that was, you said do it. I, I can't quote a name or anything, but I've had several people in there with me while I do my cares. 'cause we sit there Okay. And we talk to each other. Okay. Yeah. So it's nobody.”
- “I would like to stand by my work. And, um, I did not personally think in the moment at any time that I was being too rough with the children? Yeah. Or with the infants. I, I don't feel like I did anything out of the ordinary that they do for assessments on the unit. Okay. Um, I don't always feel like, I don't wanna say that videos aren't always the, um, greatest depiction.. Because I know she (speaking about Det. Lynch) mentioned in the one video that I grabbed yaari by his arm and tossed him over like this. And like I explained to her, I had something in my hand, um, in this left hand that was dirty. And he had milk, he had spit up a little bit Okay. And had milk in the back of his throat. And I grabbed him by his arm like this and flipped him like this and hit him on the back. Okay. To try to clear what was in the back of his throat. Okay. And then I picked him up and flipped him back over. I just feel like a lot of the stuff that we do could look rougher on camera than it actually is or that it was intended to be. Because we check for gas, like I said, like this. Yeah. We can check like this or are different ways to help them relieve their own gas.”
- “But can you, because I don't know that that's not standard of care. I don't know what to say. I don't, I don't feel like, no, that's not, not standard of care. 'cause I said I don't feel like it's not not standard of care because, so you do.”

Strotman eventually acknowledged that there were no excuses for what she could see on the screen:

- “I know I also a confliction. I've also, not to try to make an excuse because there are no excuses, but I have been out of work. Um, I was outta work for, you know, the past year. And then when I came back I was only back in for a month and a half or two months before we were taken back out again. Okay. So my, not that my practice is down right now, but between me being flustered in this situation in general and me not having actually touched a baby in weeks.”

Strotman also acknowledged that the NICU children were uniquely susceptible to injury, saying:

- “You know, them just being susceptible to these injuries, whether or not it was intentional or not. But I just want to speak for my coworkers and the staff and say that I like on their behalf and on my behalf.”
- “But, um, with my understanding from talking to the neonatologist, everybody's opinion on that is it wouldn't, because even doc, I think it was Dr. Shepherd told me that even people that set [Baby No. 1] up like this on his feet and made him weight bear could have

caused those fractures. It doesn't take, uh, I'm gonna go like this and snap their leg, or I'm gonna go like this and snap their leg. It's, that's what's so different about the NICU population is it doesn't take extreme force to hurt them. It doesn't. They're fragile. They're the most fragile. His bones are not formed like they're supposed to be. The minerals aren't there."

Strotman also acknowledged that the reenactment that she did for the detectives was very different from what was visible on the screen. About that, she stated:

- "I'm, I didn't mean, I guess to make it that different."

Strotman also attempted to deflect blame:

- "The, I feel like I'm not the only person that could have caused these fractures because of just, like I said, the susceptibility that they have to be fractured. It doesn't take much at all to fracture a premature bone and doing our regular stuff that we were taught to do."

Strotman also stated that her practice with Baby No. 1 was the same as it was with other babies:

- "I just, I don't have words. I've, I've been practicing the same, I've been doing the same stuff for the past two years at that hospital in the NICU. And uh, like I can't even count how many countless people have watched me. So I'm like, I feel like If somebody like would've saw something that was concerning, I feel like they wouldn't just let it go. They wouldn't just let me treat a baby in a bad way and then just be like, oh, I'm gonna turn a blind eye to that because I don't, I think they have more, what's the word I'm looking for? Like integrity?"

Strotman also acknowledged that she was transferring her weight onto the infants, but maintained that she had been taught to do that:

- "It looks Like I put my weight into it…No. But that's what it looks like. I'm doing What I'm taught. We were trained by Lisa James, but I, I oriented with Lanya. Um, I don't know if you've ever heard her name, but I oriented with Lanya on the unit when I came back After the 2023 incident. And before then I had three months of training."
- "Normally lean into it, yes."

Strotman also ratified that her care of the infants who were the subject of the 2023 Joint Investigation was consistent with her care of the infants in 2024. In response to the question "So this is what you've been doing with all the babies, is that correct?", Strotman said:

- "Yes. For The past two years. Okay."

Eventually, Strotman conceded that her treatment of both Baby No. 1 and Baby No. 2 as captured on video was too rough:

- "I could see how in that video it seemed more force forceful than it needed to be. But the, um, that was not the intention. I just feel like I was doing what I was taught to do. Okay. So I just feel like I don't, you do, you follow orders, you do what you're supposed to do. And then you end up in situations like this"

- “I'm not trying to hold anything back. I, um, feel like could I have been more light handed? Yeah. But do I feel like I was abusive or assaulting? [Baby No. 1]? No.”
- “I feel like it, it can be perceived as a little too rough. How, 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.”

Exhibit F: Detective Lindsay Coover, Special Victims' Unit for Henrico Police Division: March 21, 2025

Detective Coover is a detective in HCPD's Special Victims' Unit. She has been employed by Henrico County Police for a total of nine and a half years. She worked in the Patrol Division for about the first three years of her career and then pivoted to work in the Special Victims' Unit. She is certified to run the Cellebrite program, which downloads and analyzes phone system information and has a particular background and skill set in digital evidence. Her role in this investigation was to assist Det. Lynch in analyzing Strotman's phone once it was seized pursuant to a validly issued search warrant Exhibits 58 through 59, a series of text messages were also offered. The Special Grand Jury found her testimony credible.

On January 2, 2025, the night that Strotman was taken into custody, Det. Coover was the on-call detective, so she went to the Public Safety Building to provide support to Det. Lynch during the interrogation process. During the interrogation of Strotman, probable cause was developed for the seizure of her phone, and the phone was taken from Strotman. Per departmental policy, it was placed in airplane mode because that stops all external communications so that the phone cannot have in-coming or outgoing communications. Det. Coover testified that probable cause for the seizure of Strotman's phone could not be developed during the 2023 Joint Investigation. Det Coover was able to retrieve a series of text messages from Strotman's phone that were of evidentiary value. Importantly, there were text messages that referenced her prescription drug use. One text message from Strotman to a friend dated October 1, 2024 stated "Dude, I want went to bed at, like, 7:00. I took three Xanax and went right to sleep." On January 1, 2025, Strotman texts her boyfriend, " I'm going to need a couple daytime Xanax. I don't feel good. I'm scared. I'm cramps. I'm tired. My heart is hurting this has been the worst new year ever." Also on January 1, 2025, Strotman texts her mother, stating, "I could die possibly right now. I'm so sad. I'm pretty

sure I'll never go back to fucking NICU, again. No one is going to hire me after this."

In addition to these concerning text messages, and the text messages that Det. Lynch identified, Det. Coover was able to gain access to Strotman's prescription history. It showed that she was prescribed both Alprazolam, the generic for Xanax, which is used to treat anxiety, and Sertraline, which is the generic for Zoloft, an SSRI antidepressant.

Exhibit G: Mary Torrieri and Elizabeth Rogers, Investigators: Virginia Department of Health: April 11, 2025

Mary Torrieri and Elizabeth Rogers are both medical facilities inspector in the Office of the Licensure and Certification for the Virginia Department of Health. Ms. Torrieri has been a registered nurse for 20 years. Because she already had her bachelor's degree when she decided to become a nurse, she took a one-year accelerated program at Thomas Jefferson University in Philadelphia for nursing students who already had their bachelor's degrees. She worked in a series of nursing roles until she accepted employment at VDH. Ms. Rogers is also a registered nurse by training. Exhibit 60, the Plan of Correction document was also offered and received during the course of Ms. Torrieri's testimony. Ms. Torrieri and Ms. Rogers were both represented, as is their right, by counsel from the Office of the Attorney General, Charis Mitchell. The testimony was limited because the federal agency known as the Center for Medicare and Medicaid Services ("CMS") did not grant these witnesses permission to testify regarding evidence related to its part of their investigation. The Special Grand Jury found the testimony of both of these witnesses credible.

Ms. Torrieri and Ms. Rogers outlined the Plan of Correction that was prepared as a result of the 2023 survey of the HDH NICU. The survey of the HDH NICU was finalized on September 23, 2023, about 2 weeks after HDH reported the incidents that led to the 2023 Joint Investigation to CPS.

Ms. Torrieri and Ms. Rogers went to the HDH NICU located at the Skipwith Road/Forest location. Their job was to confirm that the HDH NICU was in compliance with all state and federal regulations. Their investigation revealed that HDH's failure to contact CPS within 24 hours of having reason to suspect a reportable offense of child abuse was a founded violation of patient rights. They also made a finding that the HDH NICU violated patient rights because it failed to

ensure that the facility is able to identify all staff member who came into contact with each patient in the NICU. Put differently, after investigation, it was determined that the HDH NICU did not appropriately document who was drawing blood from individual babies. There was no documentation to show who was performing blood draw procedures.

The stated reason that these two investigators entered the facility was to investigate a facility-reported incident. This means that HDH itself reported the incident. This was the incident that became the subject of the 2023 Joint Investigation. Despite becoming aware of concerning events between August 5, 2023 and September 5, 2023, HDH nevertheless declined to notify CPS until September 20, 2023. The reason offered to Ms. Torrieri and Ms. Rogers for the delay in reporting is that HDH was conducting its own internal review.

As this investigation for failure to report, on September 22, 2023, Ms. Torrieri and Mr. Rogers became aware that no one in HDH's NICU was properly documenting who was conducting the lab draw process or the IV cath insertion process for the babies in the NICU who needed these procedures. It became obvious that the staff was not documenting who was drawing the labs because one staff member might be printing the labels and another staff member might be performing the procedure. This failure to document is clinically significant because, especially in the context of potential inflicted injury, it is important to know which staff member is accessing the veins of a child who is medically fragile.

At the conclusion of this investigation on behalf of VDH and for CMS, three violations of federal regulations were identified. First, they found that patient rights were violated. Second, they found a violation of patient right to be free of abuse. Finally, they found a violation of supervision of contract staff. These violations were significant enough to be documented and made part of the final report. These deficiencies were judged to be condition level deficiencies.

As a result, HDH was permitted to put a corrective plan of action in place, which it did. These three violations were of significant concern to Ms. Torrieri and Ms. Rogers

After the violations are documented, the facility is required to write a Plan of Correction, and HDH did that. Once the Plan of Correction is written, it is reviewed and approved, as it was in this case. The CEO of HDH, Ryan Jensen, had ultimate responsibility for the Plan of Correction.

Ms. Torrieri and Ms. Rogers were called back out to HDH in November 2024 for a new federal investigation through CMS. At the time that Ms. Torrieri and Ms. Rogers testified, it was impermissible for them to discuss the specifics of the November 2024 investigation because they was precluded from doing so by federal regulation. Ms Torrieri and Ms. Rogers were generally aware that Virginia Department of Health was running a concurrent investigation to hers in 2024.

Exhibit H: Douglas Middlebrooks, Medical Facilities Inspector Supervisor: Virginia Department of Health, April 11, 2025

Douglas Middlebrooks is a medical facilities inspector in the Office of the Licensure and Certification for the Virginia Department of Health, where he has been employed since 2018. He has a Ph.D. in Organizational Management. He retired from the Fairfax County Police Department in 2018 and has specialized training as a flight paramedic. Dr. Middlebrooks was also represented, as is his right, by his counsel from the Office of the Attorney General, Charis Mitchell. His testimony was limited because the federal agency known as the Center for Medicare and Medicaid Services ("CMS") did not grant this witness permission to testify regarding evidence related to its part of his supervision of this investigation. The Special Grand Jury found his testimony credible.

Dr. Middlebrooks' role in the HDH NICU investigation in 2023 was to supervise the work that was done by Ms. Torrieri and Ms. Rogers. He was not one of the boots-on-the-ground investigators but rather was tasked with managing the specifics of the investigation in 2023, which came to VDH through complaint intake. Once the complaint is received, it is sent to the Center for Medicare and Medicaid Services to see if they want an investigation conducted which CMS did in this case. CMS authorizes VDH to conduct its investigations. Dr. Middlebrooks also explained that there are generally two types of deficiencies. The first is a standard level deficiency, which is a regulatory violation not concerning in its nature. The other type is a condition level deficiency. These are deficiencies that are quite concerning because someone could get harmed. In order for CMS to authorize VDH to investigate, there must be facts in the complaint that suggest that there is a condition level deficiency. In 2023, CMS made the determination that VDH needed to investigate based on the facts as reported. Dr. Middlebrooks is the person who assigned Mary Torrieri and Elizabeth Rogers to the 2023 VDH investigation. He assigned them to perform their investigation between September 21-26, 2023 and then to prepare a report summarizing their

findings, which they did. The report that summarized the investigators' findings and the Plan of Correction that was offered by HDH was reviewed in depth by the Special Grand Jurors.

The review process requires that the hospital address all the deficiencies, provide a timeline for addressing all the deficiencies, and show how it will keep the deficiencies from happening again. Once those criteria are met in the Plan of Correction, the facility receives a revisit to check for compliance. If compliance is achieved, CMS is notified. CMS has the ultimate authority for determining if a facility is back in compliance.

In the VDH 2023 investigation, compliance was achieved after a May 2024 revisit. Dr. Middlebrooks explained that this 2023 investigation and the findings that were made were significant and concerning. While this 2023 investigation did not close the NICU, the documented deficiencies plus the plan of correction were concerning enough to cause HDH to enter into a consent agreement in 2024.

Dr. Middlebrooks had a similar role in the VDH investigation in November of 2024, when there was concern about a novel series of violations of regulations. The complaints went through the intake process and were referred to CMS who again authorized an investigation. Health care facilities do not want to be out of compliance with CMS because continued non-compliance can affect funding through Medicare and Medicaid. When the novel instances of non-compliance were raised in 2024, Dr. Middlebrooks reported to Kimberly Beazley, the Office Director for Licensure and Certification for VDH. As part of his work, he informed Ms. Beazley of the November 2024 complaints. Based on the November 2024 reports, Ms. Beazley made Karen Shelton, MD, the Commissioner for the VDH, aware of the continuing concerns coming from the HDH NICU. Dr. Shelton leads the VDH and has ultimate authority for directives coming from VDH. The report from 2023 was still pending and had not been finalized or released to the public when the

November 2024 VDH investigation commenced.

As the facts of the November 2024 investigation unfolded, VDH was able to employ its dual function to monitor the situation. While the CMS investigation was ongoing (and CMS investigations are always federal in nature), VDH also has Virginia-specific actions that it could take to get compliance and VDH decided to use those actions in November 2024. In the 2023 VDH investigation, none of the Virginia-specific regulatory tools were used. The VDH elected to take Virginia regulatory steps to achieve compliance in 2024.

Dr. Middlebrooks testified that based on the concerns outlined in the 2024 Joint Investigation, on December 19, 2024, a Plan of Correction was created that memorialized HDH's plans to address the non-accidental fractures in the NICU. The first action that HDH took on December 19, 2024 was to place the NICU on EMS diversion for pre-term labor and suspended admission. HDH also agreed to transfer for NICU patients who were stable enough to be transferred and whose parents or guardians consented to the transfer. This process was to reduce the patient census in the NICU. At this point, HDH's NICU conceded that it was not appropriate to continue to admit into its NICU.

By December 21, 2024, HDH was rolling out a plan, if required, for the total closure of its NICU. In the event that this happened, there would be no new admissions, all patients would have to be transferred, and an observer system would have to be in place. While it sounds easy to close a NICU, there would be some children who were too medically unstable to be moved, so this planned-for measure was quite drastic.

HDH also agreed to conduct a full skeletal survey, at HDH's expense, of any NICU infant at parental request. VDH required HDH to ask a parent or guardian of each child about this. On December 23, 2024, HDH agreed that it would employ pediatric radiologists, not just radiologists,

to scan NICU infants. Finally, there was an agreement for re-education about staff reporting of abuse and safe handling of infants. HDH also agreed to background checks for all physicians who were treating the NICU infants. HDH also agreed to remove the black boxes on the video screens that were impeding full viewing of what was taking place inside the infant rooms so the entire field of view was available. HDH agreed to have facility leadership complete safety rounds twice daily in the NICU and address any safety concerns in real time, as well. HDH also agreed to review all of the video to try to determine what has happened. HDH also articulated a commitment to conduct case reviews of both "current" and "past" events with a team of physicians including a neonatologist and a pediatric radiologist who are not practicing locally. HDH agreed to have an oversight team from the corporate headquarters come and review and observe the physician and nursing care.

HDH had good reason to make these concessions. Dr. Shelton, in her role as Commissioner for VDH, has the authority to close HDH or any other facility in the Commonwealth of Virginia, and would not hesitate to do so if she believed that patient safety is being compromised. HDH did not want to be seen as not being willing to work with various regulatory agencies: the optics of that would be concerning. HDH wanted to maintain compliance so it maintained both its license and its funding stream through CMS. Finally, if they had not entered into this voluntary plan of correction, it is likely that the NICU would have been closed.

The significant non-compliant events that were initially reported in November 2024 and that became the subject of the 2024 Joint Investigation were the catalyst for VDH's request that HDH sign a voluntary compliance agreement on December 22, 2024 (the "December 22, 2024 Compliance Agreement"). HDH's NICU's license was set to expire on December 31, 2024 which gave VDH some ability to exercise pressure on HDH to make voluntary concessions. At the time

that VDH was requesting compliance with a voluntary agreement, all parties were aware that there were seven (7) babies over the 2023 Joint Investigation and the 2024 Joint Investigation who had suffered non-accidental fractures that were concerning for inflicted injury.

The December 22, 2024 Compliance Agreement between HDH and VDH became effective immediately and had the desired effect on the patient census at the NICU. As discharges occurred in the ordinary course of business and no new admissions took place, there were progressively fewer babies in the NICU. VDH continued to take this situation seriously: any failure to comply with the December 22, 2024 Compliance Agreement would mean that the conditional approval to continue to operate would be immediately withdrawn. HDH understood the import of compliance with this agreement and it was signed by the CEO for HDH, Ryan Jensen.

As part of the December 22, 2024 Compliance Agreement, HDH conducted an on-site visit at the HDH NICU on January 8, 2025. The site visitors were a team employed by HCA, the parent organization for HDH, and not known to VDH. Their findings were that the feeding protocols for the NICU infants were appropriate, and that monitoring of the NICU infants complied with AAP guidelines. The reviewing team suggested minor tweaks to nursing education for basic patient care in the NICU. Dr. Middlebrooks was concerned that HDH's HCA reviewers were identifying that there was educational deficiency identified for those who are providing patient care in the NICU.

In their own document, HCA reviewers focused on diagnoses related to so-called "brittle-bone" diseases, including osteopenia of prematurity. This was concerning to Dr. Middlebrooks because at the time that the HCA reviewers were making their report, no strong evidence that any of the seven then-identified victim children had any diagnosis of any time of bone-related irregularities. Additionally, because bone fragility can exist for NICU babies, all staff should have

already had appropriate training in the way care should be provided to avoid clusters of injuries such as these. According to Dr. Middlebrooks, HCA reviewers were searching for an explanation that made accidental injury a plausible theory to explain these two clusters of fractures despite the opinions offered by various experts. As Dr. Middlebrooks put it, "[i]f an identification of some type of metabolic bone disease is identified in a patient, it is easier to explain a fracture as a disease process instead of a handling process." Even in the VDH-mandated evaluation process to keep its licensure, HDH and HCA are advancing a flawed theory of accidental injury. In fact, even after someone is arrested for child abuse, HCA's reviewers are focused on managing bone health and reducing osteopenia of prematurity as a means of explanation.

On January 31, 2025, about two months after the injury to Baby No. 1 is discovered in November of 2024, HDH submitted what it referred to as its "Quality and Reopening Plan." Because of the need for NICU beds for patients in the Commonwealth, it was not going to be possible to keep the HDH NICU closed forever, so this was an attempt to make sure an access to care problem did not develop. During the closure of the HDH NICU, other regional NICUs had to pick up the load created by HDH's inability to accept new admissions. A meeting regarding reopening was held on January 31, 2025, and representatives from VDH were invited to attend. At that meeting, HDH identified five areas for improvement in their NICU: nursing services, occurrence reporting, infection prevention, education, and documentation. With respect to the "pathway forward" for the NICU, HDH commented that they had four major categories that needed improvement: clinical, neonatology, radiology, and nutrition. They also identified risks and mitigation related to the reopening of the NICU. Dr. Middlebrooks expressed concern about the tenor of this presentation: by the time it was being made at the end of January 2025, an abuser was under arrest and there had been no additional fractures seen on any child; nevertheless, HDH

continued to discuss the potential of accidental fractures related to incidental care being the potential source of injury.

Despite the eagerness of HDH to get its NICU reopened and put this chapter behind it, VDH was far more circumspect. On February 10, 2025, an amended Conditional Agreement was entered. Its key feature was extending VDH's authority over HDH until April 1, 2025. Throughout this process, VDH was faced with managing the need for patient care with the need to keep patients, particularly the vulnerable patients in the NICU, safe. This was all happening in the framework of HDH being a major healthcare provider in Henrico County, a large suburban county. The first draft plan for reopening the NICU was circulated on February 18, 2025. There was a final Consent Agreement that was signed on March 31, 2025 that covered HDH's actions through April 11, 2025.

Exhibit I: Karen Shelton, MD, Commissioner: Virginia Department of Health: April 11, 2025 and May 9, 2025

Karen Shelton, MD is the Commissioner for the Virginia Department of Health. She received her undergraduate degree from Wake Forest University and her medical degree from the University of Virginia. She completed her training as an obstetrician-gynecologist, and then practiced in her hometown of Bristol, VA for 19 years. She joined VDH in 2016, pivoted out to serve as a Chief Medical Officer for an hospital system, and then went back to VDH as the Commissioner after she was appointed to the position by Governor Glenn Youngkin. As the Commissioner, she has ultimate authority for the agency. Mary Torrieri, Elizabeth Rogers, and Douglas Middlebrooks all work for her. Dr. Shelton was represented, as is her right, by her counsel from the Office of the Attorney General, Charis Mitchell. She was offered and received as an expert in both public health and obstetrics based on her education, training, and experience. The Special Grand Jury found her testimony credible.

In 2023, the facts of the 2023 Joint Investigation did not rise to the level where Dr. Shelton was informed of their existence, and she was unaware in 2023 of the cluster of fractures that framed the concerns of various stakeholders. She became aware of the 2024 Joint Investigation as the criminal investigation was underway. As she was informed of the injury to 2024's Baby No. 1, she was also notified of the 2023 Joint Investigation and the cluster of infants who were victims then. This immediately put Dr. Shelton on what she described as "high alert that this was a very concerning feature." Dr. Shelton also knew that it is generally true that unexplained fractures in non-mobile neonates is pathognomonic for child abuse because of her education, training, and experience.

Dr Shelton knew about the injuries to the 2023 Joint Investigation victims and Baby No. 1 from the 2024 Joint Investigation on December 17, 2024 when the injuries to Baby No. 2 were

discovered. She was gravely concerned when she learned of the injuries to Baby No. 2 because there were open questions as to whether they were injuries of abuse versus quality-of-care handling of the babies, and all of this was happening in the context of the previously reported 2023 injuries.

From Dr. Shelton's point of view, Baby No. 2's injury was the final straw. Once she became aware that Baby No. 2 had a constellation of unexplained fractures, Dr. Shelton did not want to wait the amount of time it would take for a federal action to protect these children. For this reason, she elected to act immediately and initiated a proceeding to find that the children still in the NICU were in immediate jeopardy. At this point, Dr. Shelton began conferring with the Commonwealth Secretary for Health and Human Resources and the Office of the Attorney General about the implementation of protective measures for the NICU infants.

On December 24, 2024, Dr. Shelton was informed of the injuries to Baby No. 3 when this child's injury came to light as part of the corrective action planning items that were being suggested by VDH. Initially, Dr. Shelton considered closing the NICU but was concerned about the feasibility of so doing because at the time, the census was 31 infants, some of whom had a very high acuity. There were not enough high-needs NICU beds in the Richmond VA area to absorb all the HDH NICU infants.

For this reason, Dr. Shelton took a different approach. Transfers to HDH NICU were halted and admissions were suspended. VDH had direct conversations with HDH leadership from the time that VDH decided to take action on December 18, 2024. Dr. Shelton was interacting directly with the CEO of the HDH, Ryan Jensen and Dr. Lunn, HCA division president to whom Mr. Jensen reports. Mr. Jensen is not a physician, but Dr. Lunn is. Mr. Jensen and Dr. Lunn understood that this was an extraordinarily grave situation, and they were willing to collaborate for the safety of the NICU infants. When Dr. Shelton was interacting with hospital personnel, it was obvious to

her that the HDH/HCA personnel still believed that the injuries were the result of metabolic bone disease and not inflicted injury.

As the investigation developed, Dr. Shelton became convinced that the observed injuries were not the result of metabolic bone disease but were the result of inflicted injury. The reason she became convinced of the non-accidental nature of the injury is that she observed Strotman on video interacting with the victim children in a manner that was concerning. For that reason, it is Dr. Shelton's opinion, to a reasonable degree of medical certainty, that the injuries observed were inflicted and not accidental. She also believes that these children were at significant risk for metabolic bone disease which may have made them more susceptible to breaks but that with appropriate, non-traumatic handling, these breaks should not have happened.

The corrective action plan that was jointly negotiated by Dr. Shelton on behalf of VDH and Dr. Lunn, the division president of HCA was the result of a tremendous amount of collaboration and included input from CPS. One of the key features was the observer program: the same program that HDH had been out of compliance with between December 3 through 17, 2024. Dr. Shelton articulated that the private room structure of this NICU (as opposed to the other model for NICUs, which has a large open bay where all the babies are lined up in their bassinettes around a big room) and the privacy that it provides made the observer program a priority for VDH because they wanted to make sure that "no one went in alone to a baby's room. We always had someone go in with them to make sure that they were taking care of the baby." This is the same plan that also features the limitation of new admissions and the opportunity for transfer for babies who were medically stable enough that it was appropriate to do so.

An additional feature of the voluntary corrective action plan was that Dr. Shelton wanted every parent who had a child in the NICU to understand the situation. As Dr. Shelton put it, the

parents "needed to know the concern of unexplained fractures in the NICU. So part of the requirement of this document was that every parent got a conversation, informed consent, about what was going on…and whether or not the wished to be transferred to another NICU. They were given that option. And if they were going to be transferred, it would be at the hospital's expense…." Those conversations did not make a material difference to the patient census: of the 31 babies who were in the NICU on December 18, 2024, only one opted for a transfer, and that was a family with a previous connection at VCU. There was some concern that these conversations minimized the risk in explanations to parents, but that concern was investigated by Ms. Torrieri and Ms. Rogers and was meritless.

VDH also insisted that each parent of a NICU be offered the opportunity to have a skeletal survey or "babygram" to confirm that there were not additional, unknown and unidentified fractures on other babies in the NICU. Because of the nature of x-rays, informed parental consent would be required to do these films. Only about half of the families were willing to consent to these babygrams. At that point, there were still 30 babies in the NICU, so 15 families consented to the skeletals and 15 declined.

These skeletal surveys led investigators to the injury on Baby No. 3, which was discovered on December 24, 2024. Baby No. 3 had a single rib fracture. The offered history from HDH was that this child had gone through an episode of vigorous resuscitation. Dr. Shelton offered this opinion that this single rib fracture was one of the kinds of fractures that can be occasionally seen and explained in the context of resuscitation. Baby No. 3 did not have the pattern of fractures that the other babies had that were so concerning.

Dr. Shelton also commented that VDH required that all staff and personnel were trained to recognize possible abuse and mandatory reporting requirements. VDH also required a separate

study to confirm that the nutrition being received by all NICU infants was adequate to offer prevention of metabolic bone disease, which it was. Dr Shelton also noted that each physician was required to submit to a background check.

Dr. Shelton also addressed the issue of the video cameras. As she noted, two separate camera systems were installed after the 2023 Joint Investigation. The first set of cameras, the Angel Eyes system was one that parents could access in real time. The Angel Eyes system is designed to be turned on and off during care for baby. The Angel Eyes system does not record.

The other video camera system in each individual NICU room was recording continuously but the system was not being monitored in real time by any HDH personnel. It also had a so-called "black box" feature to protect the privacy of nursing mothers. The black box covered the chairs in the rooms. VDH compelled the removal of the black boxes, but each family needed to know that it was removed, and all the staff needed to know it had been removed.

At the beginning of VDH's 2024 involvement in this matter, Dr. Shelton was concerned that HDH was taking an unreasonable position in their belief that the injuries were the result of metabolic bone disease. Dr. Shelton explained her view of HDH's position this way, "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….But part of what you have to do is to be objective about, we have a problem, what is it?" While it was difficult to ascertain if HDH was objective in its perspective, they were invested in finding answers to explain what happened to the babies in 2024.

Dr. Shelton also testified regarding the limits of the authority of VDH to suspend or revoke a license or to suspend or revoke admissions. VDH's authority to act must go through an Administrative Process Act. In other words, VDH doesn't have the authority to summarily

suspend. Instead, VDH's authority is far more limited. It can put a facility on notice that it would like to suspend, and then the facility has time to respond to that notice. Because of that limitation, VDH will usually try to come to agreement with a facility as to VDH's concern and the next steps. That is generally handled in the framework of a consent agreement, as was done in 2024 with the HDH NICU. When a consent agreement is reached, the facility also agrees not to go through the hearing process, and the corrective period begins as soon as the document is signed.

With respect to the 2024 HDH matter, VDH negotiated a very strong consent agreement. HDH agreed to implement everything that VDH wanted. Not only did they get the children who were stable enough to be transferred who wanted to leave out of HDH, admissions were suspended, and the observer program meant that there was an additional set of eyes on each child. When Dr. Shelton testified, the HDH NICU was still under a revised consent agreement that was to remain in place until June 30, 2025.

Dr. Shelton then outlined the entire life cycle of the 2024-25 consent agreements with HDH. During the timeframe of the initial consent agreement, one of the issues for review was that the whole hospital's licensure was up for renewal. Dr. Shelton found herself in the position of having conversations about how to renew the hospital's license in good faith knowing that the concerns about the NICU were grave. Working with their lawyers, they agreed to grant a renewal license to HDH with a conditional license on the NICU services. This carried a lot of leverage because HDH needed its license in order to be able to provide care. The original condition on HDH's license was through April 1, 2025: VDH agreed to condition its renewal of their full hospital license but condition the NICU license such that to operate the NICU, they had to reapply by April 1, 2025 to operate the NICU.

Dr Shelton also addressed VDH's plan with respect to admissions at the NICU. As this

investigation unfolded, Dr. Shelton recognized that VDH was either going to need to close the NICU completely either short-term or long-term or reopen it for admissions. Strotman was identified as the perpetrator of the non-accidental trauma quickly, which alleviated a lot of the safety concerns for the babies that VDH had. VDH wanted to keep admissions 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. By the end of January 2025, all the videos had been viewed, and the census was at about five babies. HDH had also been very compliant with the Corrective Action Plan. At that point, VDH did not believe that closure of the NICU, either short-term or long-term, would be an appropriate solution; rather, VDH believed that planning for readmission was acceptable.

Finally, Dr. Shelton commented that from the time that she became involved in this matter in December 2024, she found "in interactions with the hospital, everything that they did was very collaborative, very eager to ensure quality and safety of the babies from that time forward. It is difficult for me to speak to anything they had done prior." This concluded Dr. Shelton's initial testimony.

Dr. Shelton was recalled by the Special Grand Jury to testify again on May 9, 2025 and Exhibits 78 and 79 were offered and received during the course of her testimony. She was recalled to comment on the CMS report that was dated April 11, 2025.

The April 11, 2025 report showed that facility was determined not be in substantial compliance with various requirements because of the November and December 2024 investigation. This was the same investigation that caused VDH to negotiate its agreement with HDH, but this report outlines the findings that were made on the federal side of the investigation. This report discussed the finding of immediate jeopardy that was made on December 18, 2024 and

was then removed on January 8, 2025 after they had verified on site that there was a corrective action plan in place.

The December 2024 immediate jeopardy posture was directly related to the unexplained fractures from 2023 and 2024, but the investigators who were sent in to evaluate found additional problems inside the NICU that were expansive and concerning. Investigation revealed that there were concerns about the efficacy of the governing body of the hospital, The specifics that underpinned this finding were a failure to identify and investigate discrepancies in radiology reports and about a consent not being attained prior to the administration of a vaccine, as well as a concern about a failure to prevent child abuse inside the NICU. There was concern about failure to perform investigations to rule out abuse and neglect, failure to implement a well-organized nursing service, and failure to provide oversight around issues related to infection prevention and with a bacterial MRSA outbreak. Put differently, this finding was an expression regarding the quality overall of various aspect of the hospital and the governing body to make sure that HDH was a place of safety and quality of care. Once those deficiencies were noted, there was a corrective plan that was implemented with hospital leadership in charge of the improvement noted.

With respect to this finding and how it impacted the 2024 Joint Investigation, Dr. Shelton outlined a specific problem with the radiology reviews from November 2024. One of the 2024 Joint Investigation victims had an x-ray of an affected limb on November 20, 2024, and the reviewing radiologist missed a fracture that was subsequently visualized the following day, November 21, 2024. It appears that the November 20, 2024 radiologist did not document that the fracture was not seen on November 20, 2024 even though it existed on that day, nor was the chief medical officer informed of the miss. There should have been a system in place at HDH were a discrepancy was noted and an escalation up the chain should have happened but didn't.

The CMS report also commented that another way that HDH failed to protect patients was in the context of the unexplained, non-accidental fractures in 2024. The report noted that HDH failed to "prevent abuse, identify injuries of unknown origins as indicators of potential abuse or neglect, and report and investigate injuries of unknown origin." The report specifically commented that the facility was not reviewing the video from the installed cameras to audit or perform observations of care. On the contrary, the video had only been used previously to look at hand sanitation hygiene in the context of a complaint. There was also a notation in the report that despite the incidents in 2023, HDH discontinued its daily physician musculoskeletal head-to-toe assessments of NICU babies in July or August of 2024 because of staffing shortages, even though they had not yet returned Strotman or another nurse to work. Additionally, there is a notation that by August of 2024, they were no longer contacting the chief medical officer to notify them of concerns with the NICU babies that were documented on daily assessments.

Of concern, this report also documents for the first time concerns about a child from 2022 who was the victim of unexplained fractures that were similar in nature to the 2023 and 2024 Joint Investigation victims' fractures. The Virginia Department of Health was never made aware of this victim until 2025 when this investigation and accompanying report were being prepared. As noted from Dr. Shelton's earlier testimony, HDH took responsibility for the failures documented in this report and suggested the corrective action plan. As a result, HDH implemented the observer program, daily physical exams for NICU babies, a rapid debrief policy, and prompt notification to leadership. All these things were to be implemented by February 5, 2025. HDH was also required to commit to an appropriate mandatory reporting response to CPS. VDH also mandated that concurrent video review start. Concurrent video review finally commenced at VDH's insistence in December 2024. VDH was so concerned about concurrent video review and daily physical

checks that they insisted on documentation of those items.

This review also uncovered a significant history of MRSA in the NICU. Before this review took place, HDH had been dealing with a yearslong MRSA outbreak, one that the reviewers believed could be easily controlled by the implementation of a quality assurance program. This massive MRSA outbreak was something that VDH truly started to understand incident to its investigation into the non-accidental fractures. In the review that they did, the reviewers were not searching for a MRSA outbreak, but it was there and could not be ignored. In response to the concerns about MRSA, HDH agreed to implement a MRSA scorecard and to track quality indicators related to the observed MRSA outbreak.

Patient safety was also a documented deficiency for HDH. HDH did not have an appropriate Quality Assurance Program in place to document adverse events. The purpose of documenting the adverse events is to log them, do an investigation about why they happened, and figure out how to keep them from happening again.

In terms of patient safety, another documented deficiency that existed is that there were no clear records to show if the neonatologists who were charged with identifying abuse had been appropriately trained on identifying symptoms of abuse. Dr. Shelton's understanding of what the investigators found was that the neonatologists simply didn't know what they were looking for in terms of symptomatology. As Dr. Shelton put it, the whole reason for the daily head-to-toe assessments was to screen for abuse, but the neonatologists didn't have the appropriate training to know what they were trying to find. Dr. Shelton also expressed frustration that even into 2024, after the 2023 Joint Investigation and the failure to timely report to CPS, HDH seemed to suggest that it still wanted to conduct an internal investigation before it reported concern for abuse. This troubled Dr. Shelton because VDH was clear with HDH: the obligation is to report once the

suspicion is raised, not to investigate first and then report.

As to other deficiencies in the realm of patient care, there were documented concerns that nurses who were new to HDH from other facilities did not have appropriate onboarding training. While it is not clear whether the incoming nurses had the required skills and competencies, what is clear is that no one from HDH had documented whether they had the required skills and competencies to care for NICU infants. There was also documented failure in the category of supervision of contract staff. Reviewers found that various contract nurses did not adhere to standard competencies and practices in care of the NICU babies. Additional investigation uncovered documentation deficiencies and checkoff deficiencies. Moreover, the investigators found that some of the formula being given to the NICU babies was past its expiration date. There was a concern that training by preceptors was documented by pre-populated fields rather than documenting what new NICU nurses actually knew and could do. There were also portions of the medical records that were unclear and made it difficult to determine which health care provider had done what for individual NICU infants. Also of note, the neonatologists who work at HDH are not employees of HDH, but rather subcontractors. As a group, they did not comply with the investigators requests for interviews and VDH did not have any means by which they could compel those interviews, so VDH interviewers never uncovered what the neonatologists knew. There was also documentation that individual isolettes were not cleaned and sanitized properly, which Dr. Shelton described as "disturbing." This failure to appropriately clean individual isolettes certainly did not help in HDH's attempt to rid the NICU of MRSA. Various interviews with employees also showed that there was no National Infection Prevention guidance being followed by HDH; instead, HDH was following a so-called "playbook" that provided a list of corporate best practices. Essentially, VDH came in because of the concern about non-accidental fractures and what

investigators found was a constellation of other violations.

During what can only be described as the crisis phase of the 2024 Joint Investigations, VDH was meeting with control center employees from HDH on a daily basis. Dr. Shelton described these individuals who made up the leadership team as "very on board and present" in December 2024, presumably because their licensure was on the line. The CEO and the CMO of HDH were both regularly present at these meetings, as was the VP of Quality. Dr. Shelton reported that even in December 2024, it was the articulated position of the HDH leadership team that these fractures were the result of metabolic bone disease and not inflicted injury. Dr. Shelton remained concerned because their assessment did not square with her understanding of the state of the medicine or the literature. When the investigation began, Dr. Shelton didn't know if the cause was trauma or quality of care, and if it was a quality-of-care issue, it was still a major issue because of the number of babies affected. At the beginning of the investigation, HDH did not share with Dr. Shelton what the basis of its opinion that these were spontaneous injuries was. Even if it was a quality-of-care issue, Dr. Shelton believes that it is absolutely possible to treat a child with osteopenia and never have that child have a single fracture. She found it puzzling and concerning that HDH's control employees were resistant to the possibility that there could simply be an abuser working amongst the ranks. HDH's posture with respect to abuse did not change until they saw the video footage of Strotman for themselves.

Dr. Shelton commented that once HDH's leadership team saw the videos, Dr. Shelton believes that the team had the appropriate response. Strotman was quickly terminated. This was a marked shift from the decision to return Strotman to the NICU in September of 2024. Dr. Shelton does not know who permitted Strotman to return to work or the reason that the decision was made to return her to work. VDH asked those questions, but HDH declined to answer, calling those

decisions confidential employment/human resources matters. HDH would not disclose who placed Strotman on leave in 2023 or 2024 or why, either. 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.

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.

Dr. Shelton ratified that in 2023, HDH waited nearly six weeks before they complied with their CPS reporting requirements. In 2024, there was full compliance with all reporting requirements, both to CPS, VDH, and VDH's coordinated entity, CMS. Also of note, VDH never learned who was responsible for the trajectory of Strotman's career with respect to her termination process as a result of her abuse of the NICU babies.

Exhibit J: Sharon Negron, Senior Investigator: Virginia Department of Health Professionals, April 18, 2025

Sharon Negron is a senior investigator with the Virginia Department of Health Professions ("DHP") in their enforcement division. She has served in this position for about two and a half years. She received her nursing degree in 1988 from Boston College's School of Nursing and has a background in emergency room nursing, newborn nursery nursing, and pediatrics. She also worked for a pharmaceutical company as a nurse. She does investigations for all the boards, not just the Board of Nursing. Her caseload is about 20 to 25 cases a year and she enjoys the work she does. Exhibits 68-76, exhibits related to her investigation of Nurse Strotman, were also offered during the course of her testimony. Ms. Negron was represented, as is her right, by her counsel from the Office of the Attorney General, James Rutkowski. Ms. Negron was permitted to testify in front of this body because her counsel sought and received an Order from the Circuit Court permitting her to discuss this confidential information. The Special Grand Jury found her testimony credible.

Ms. Negron described the function of DHP, the Virginia agency with oversight of all the individuals who have healthcare licenses in the Commonwealth. DHP's primary purpose is to make sure that the public is safe and that patients are getting safe care. In her role as a Senior Investigator, she is a fact finder who makes no recommendation to the Board. She collects information, prepares a report that, once finalized, she submits to the board that requested it. Whichever board requested it is then charged with determining if any regulations have been violated. If there is a violation, the board decides if it wants to act. The actions available to the various boards can be de minimis and can go all the way up to a revocation of license. The relevant board typically does not act to summarily suspend a license before an investigation is done. Once a board reviews a case, the various boards do have the authority to summarily suspend a licensee

if there's concern that they are putting the public at risk or their actions could cause harm to the public. Ms. Negron deeply believes in the investigatory and due-process components of this process. This matter involved a Board of Nursing investigation. The Board of Nursing is made up of a group of nurses and two citizen representatives.

Investigator Negron was assigned to investigate matters related to Strotman's involvement in the 2023 and 2024 Joint Investigations. As requested, she completed an investigation and submitted a report that was offered to the Grand Jury as Exhibit 68. Her investigation started when DHP received a series of complaints about Strotman from a variety of sources. In addition to notifications from media reports and citizen complaints, DHP received a report from Douglas Middlebrooks, Ph.D. on January 6, 2025.

From her investigation, Ms. Negron learned that Strotman was hired as a new nurse at HDH in 2019 after she became a registered nurse. She worked the entirety of her career at HDH. She was assigned to the NICU from May 2022 to November of 2024. Ms. Negron learned that Strotman had a diagnosis of major depressive disorder and generalized anxiety disorder.

In 2023, there was a cluster of four patients at HDH's NICU with unexplained fractures. HDH determined that she was the only common caregiver for all four patients, so they placed her on administrative leave before they notified law enforcement. This placement on administrative leave is significant as part of a Board of Nursing investigation because when there is a concern that causes a nurse to be placed on administrative leave, the Board's position is that it should have been made aware of that placement. 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. Notification was made to DHP on January 3, 2025. Notification was made to DHP by the CEO of

HDH, Ryan Jensen.

Ms. Negron went on to outline the return-to-work plan that was established for Strotman by HDH in September 2024 after Strotman was out of work for a year following the events that led to the 2023 Joint Investigation. She received four hours of professional development and was connected to a preceptor and completed four shifts with the supervisor. Shortly after Strotman's return to work, the injuries of Baby No. 1 of the 2024 Joint Investigation were identified. In 2024, there was immediate reporting to CPS but not to DHP. As the 2024 Joint Investigation continued, there were more babies with fractures identified. Surveillance video was reviewed, and Strotman was identified as an individual with concerning behaviors. If DHP had been put on notice of either the allegations or Strotman's placement on administrative leave in 2023, an investigation would have been conducted at that time. Moreover, if DHP had been put on notice that Strotman was placed on administrative leave when it happened on November 2024, Ms. Negron's investigation in 2024 would have started then instead of six weeks later. DHP's investigation was delayed because of HDH's failure to notify them of the change in employment status.

Ms. Negron began her investigation in the ordinary course of business by seeking additional comment from those in the public who initially filed complaints. On January 6, 2025, she requested relevant information from Henrico County Police Division, but because of ongoing investigatory concerns, that material could not be provided to her. On January 31, 2025, she requested HDH and its parent entity, HCA, for personnel records related to Strotman. Those records were received by Ms. Negron on February 8, 2025. Ms. Negron also searched Strotman's Prescription Monitoring Program information on February 12, 2025. Ms. Negron searched for Strotman's prescription history going back to 2022. Notably, Strotman had valid prescriptions for THC, alprazolam, which is a prescription benzodiazepine for anxiety, lorazepam, which is also a

benzodiazepine. Strotman had a medical certificate for cannabis products that was issued to her by the Medical Wellness Center. That was offered and received as Exhibit 76. The offered reason for the need for the certificate was fibromyalgia, which is an umbrella term that is usually diagnosed by symptoms. For this reason, it is difficult to apply objective clinical criteria to it. There was no dosage or limit reflected on Strotman's certificate. Based on the certificate that was provided to Strotman, she could treat with as much THC as she chose. HDH never drug tested Strotman except for a pre-employment screen in 2019. DHP has no statewide requirement of mandatory random drug testing for nurses.

Ms. Negron also reviewed evidence and records related to Strotman's mental health. On March 5, 2025 and March 7, 2025, she received records from Virginia South Psychiatric & Family Services. Those records were offered and received as Exhibit 72. Strotman was being treated by Dr. Amara, who provided care to Strotman on January 2, 2025. On that day, she was being seen for medication follow up and her chief complaint was generalized anxiety. There is no reference to the use of THC, but Dr. Amara changed her prescription and scheduled a four-week follow-up appointment. He counseled her and made a referral to psychotherapy.

Ms. Negron also reviewed notes from a visit to Dr. Amara that took place on February 18, 2025, post-arrest. The treatment plan was to continue current medication regimen with a focus on dose optimization (increasing) and psychotherapy. Strotman's record from May 2024 indicates that Strotman was depressed, anxious, and overwhelmed. Medication was prescribed and she was referred to therapy. A history of substance abuse: cannabis is documented in the record, which is concerning because she is self-seeking medical THC for her fibromyalgia diagnosis. The record from her visit in April 2024 is nearly identical, showing symptoms of depression and anxiety and a substance abuse history involving cannabis. Her records from the summer of 2024 don't show

an appreciable change. In July 2024 and September 2024, she is still symptomatic. Both months, the amount of alprazolam that is being prescribed is again increased.

Ms. Negron also interviewed Dr. Amara on two occasions, March 21, 2025 and March 25, 2025. According to Dr. Amara, Strotman told Dr. Amara that she was not involved with the NICU injuries. She also told Dr. Amara that she was hospitalized at age 13 for depression and anxiety. Dr. Amara also told Ms. Negron that Strotman is not stable enough to practice nursing.

Ms. Negron also completed several significant interviews. On March 5, 2025, she interviewed Sarah Scheer, who supervised Strotman in the NICU. Ms. Scheer has known Strotman since 2022. Strotman was placed on the day shift when she returned to work in September 2024. Strotman told Ms. Scheer that she needed to be on the day shift because Strotman was depressed and having trouble sleeping so night work was difficult for her. Ms. Scheer thought Strotman's clinical skills were average and that she was becoming better at taking care of higher acuity patients. Ms. Scheer had to discipline Strotman once for tardiness in 2023. Ms. Scheer was the supervisor who informed Strotman that she was being placed back on administrative leave on November 22, 2024. Ms. Scheer was shown the concerning videos of Strotman interacting with Baby No. 1 as part of her interview. Ms. Scheer described the actions of Strotman as very careless. For some of the videos she reviewed, she said that "everything she does in this video is concerning." She also noted in other videos that Baby No. 1 was becoming both bradycardia and had oxygen deceleration because of Strotman's actions. Strotman should have noticed this and changed her behavior. Ms. Scheer was also offered videos of Strotman interacting with Baby No. 2. She commented on the amount of pressure that Strotman was placing on Baby No. 2. She was also shown videos of Strotman's interactions with Baby No. 4 from the 2024 Joint Investigation and she was similarly concerned about Strotman's manipulation of this child. Ms. Scheer's overall

assessment of the collective videos was that they were "shocking" and that "they did not align with the person she knew Erin Strotman to be." Ms. Scheer additionally commented that she "doesn't know what [Strotman's] intentions were, but what she witnessed on the videos did not align with their standards of care. [Ms. Scheer] would have corrected [Strotman] right away if she saw her doing any of the observed behaviors on the videos." Ms. Scheer also commented that all the NICU nurses have been instructed that it is impermissible to use manual maneuvers to expel abdominal gas. Ms. Scheer does not believe that Strotman is safe to practice nursing in the NICU.

Ms. Scheer also commented that Strotman shared details related to her mental health, especially her struggle with depression. Ms. Scheer also shared that various nurses commented on the fact that once Strotman was placed on administrative leave in 2023 that there were no more non-accidental fractures and that the issue reappeared once Strotman was returned to work. Other staff also gossiped about Strotman's attendance/tardiness, but no one had ever complained about her direct care of patients.

According to Ms. Scheer, Strotman's return to work was uneventful. Strotman was informed of the installation of the cameras. She was not required to complete any psychiatric evaluation, nor was she asked about any drug use.

After the interview with Ms. Scheer was completed, Ms. Negron interviewed Jennie Whitaker, the Director of Nursing for HDH. Ms. Whitaker told Ms. Negron that the reason that Strotman was placed on administrative leave in 2023 is that she was a common caregiver for the children with fractures and she was placed on leave as a "precaution." Ms. Whitaker said that HDH didn't contact DHP because they didn't have substantiated evidence or clinical concerns in 2023. Ms. Whitaker commented that she was "surprised" by the level of force used in the videos.

Ms. Whitaker also informed Ms. Negron that no one monitored Strotman's movements on video after she was returned from administrative leave. In fact, Ms. Whitaker said that no one was watching any of the videos. Ms. Whitaker did not believe that Strotman was safe to practice nursing and that she caused harm to the infants.

Ryan Jensen, the CEO of HDH also spoke to Ms. Negron. He's been the CEO of HDH for about five and a half years. He doesn't hold a license to practice any health profession. When they placed Strotman on administrative leave in 2023, she was placed on paid leave, but because they did not place any additional restrictions on her, she could have gone to work at any other healthcare provider in the Commonwealth of Virginia, and DHP never would have known, despite what proved to a huge risk for patient care and safety. HDH could have avoided this by reporting that they had placed a person on administrative leave. Jensen conceded that they never monitored the care she was giving over the surveillance system that they had installed for that purpose. The offered reason for the failure to review was that they thought the fractures were a clinical issue and that micro-preemies have "spontaneous fractures." This theory of "spontaneous fractures" is contrary to the state of the medicine. Nevertheless, Jensen was "shocked" by the videos. He said that "she did not deliver the standard of care expected by an HDH employee. She placed pressure and force on the babies. The videos are unexplainable."

Tracy Bowers is the VP of Human Resources at HDH and she had a great deal of information about Strotman's employment history. Strotman was promoted during her employment at HDH and she met expectations on every evaluation. At no point during her employment was she ever drug tested. There were no conditions placed on her for her to return to employment.

Ms. Bowers also stated that Strotman was required to report the use of any medication that

could impair work performance or employee health. The two that Strotman should have reported that she did not report were the Alprazolam and the THC. HDH relies on employee self-reporting. Additionally, HDH/HCA employees are allowed to use a form of THC oil because there are new Virginia regulations that Virginia employers are not allowed to discriminate against individuals who use cannabis oil. HDH has a regulation that individuals are not allowed to use edibles or gummy forms of cannabis.

During the investigations, Ms. Negron's supervisor, Sherry Foster reviewed the reporting requirements pursuant to 54.1-2400.6 with counsel for HDH. In response, counsel wanted to know if HDH was under investigation for violation of those regulations.

Ms. Negron also reviewed the policy about reporting abuse and neglect that was in effect at the time of the 2023 and 2024 Joint Investigations. She also received and reviewed the Code of Conduct that was in effect during the same period. The Code of Conduct includes the Substance Use in the Work Place Policy. The policy prohibits the use or possession of alcohol and drugs, marijuana or paraphernalia by an employee on the facility or during work hours. It also prohibits being under the influence during the workday. The policy has few enforcement mechanisms.

On March 18, 2025, Ms. Negron interviewed Dalanya Smith, who was Strotman's preceptor when Strotman returned to work in September 2024. Strotman told Smith that she was fine and didn't need a buddy. HDH just wanted her transition to be smooth and for her to be aware of the policies put in place while she was away. Smith also commented that the bicycle method for reducing gas has never been taught to HDH NICU staff.

Ms. Negron also interviewed Lisa James, the NICU nurse trainer for HDH. She was in charge of Strotman's return to work training. Her instructions were limited: she was to make sure that Strotman completed the abuse and neglect training required as part of HDH's agreement with

the Commonwealth's Attorney's Office. She was also to finish the new training related to heel sticks. Ms. James was also asked to review the concerning 2024 videos. After reviewing these videos, Ms. James said that the skills demonstrated were very poor and very low. She would have graded her "very low." James also commented that she "wanted to know where Strotman learned the inappropriate maneuvers seen on the videos." James said that the babies seemed to be in pain when Strotman applied pressure to them. She believed Strotman caused harm to the babies and that she was not safe to work in the NICU.

Jennifer Young, the VP of quality at HDH since January 2024 was also interviewed on March 18, 2025. In 2023, she did not believe that Strotman caused these fractures. In 2023, Young was of the opinion, despite all the evidence to the contrary, that the fractures to the babies were caused by a clinical issue, not a person. Young was not in the group who permitted Strotman to return the NICU in 2024. After she was asked to review the videos of the 2024 incidents, Ms. Young described the behavior as "inappropriate." Ms. Young also said that her behavior was very different when she was alone in a room than when she was in a room with another person. Ms. Young also told Ms. Negron that there were videos where Strotman was able to provide appropriate care. Ms. Young was of the opinion that Strotman was not safe to practice medicine and that she hurt the NICU babies.

At the time that she testified, Ms. Negron was still working on a supplemental report, which included interviews of other involved parties. Mandy Winton was one of Strotman's supervisors. When she was interviewed, she said she didn't believe that Strotman would ever have harmed any of the NICU infants.

Finally, Ms. Negron conducted an in-person interview of Strotman herself on April 8, 2025. Ms. Negron was "shocked" that Strotman agreed to an interview because she was advised by her

criminal defense attorney not to participate in an interview with Ms. Negron. She was cooperative and matter of fact when she answered Ms. Negron's questions. She told Ms. Negron that she had been properly trained. She rated her clinical skills as a 8 or 9 out of 10. She did not believe there was any area where she needed to improve. She denied ever receiving any verbal or written warnings. She said that her major depressive disorder was cured. She said that she did not know that she had depression until she read an evaluation that was done while she was in jail. She denied a history of psychiatric hospitalization. She denied any domestic violence. She agreed that she commenced marijuana use after she started her nursing career. She sought employment after she was placed on administrative leave but was unable to secure any employment.

Ms. Negron offered Strotman an opportunity to review the concerning video clips. Despite having been shown some of the videos on the evening of her arrest, Strotman nevertheless denied having ever viewed them. After viewing them, she told Ms. Negron that she was still safe to practice nursing and that she did not believe that there was anything she needed to do to prepare to return to nursing.

Exhibit K: Robin Foster, MD, Expert Witness: Director of the Child Protection Team and Professor of Medicine, Virginia Commonwealth University

Robin L. Foster, MD is a Professor of Pediatrics and Emergency Medicine at Virginia Commonwealth University. As part of her employment at VCU, she also leads the Child Protection Team. She received her undergraduate degree from the College of William and Mary, and her degree in medicine from VCU. She became board-certified in general pediatrics in 1993. She worked in the pediatric emergency room and became one of the medical directors of the Child Protection Team in 1992. She then went to St. Christopher's Hospital for Children in Philadelphia to complete a fellowship in pediatric emergency room medicine. After that, she returned to VCU after she was board-certified in pediatric emergency room medicine. In 2011, she was board certified in child abuse medicine. She maintains a robust clinical practice in addition to her teaching and research obligations. She is nationally recognized for her work in the field. As part of her work, she is regularly in and out of the NICU at VCU and understands standards of practice for both medicine in the NICU and for nursing care in the NICU. For these reasons, she was offered and received as an expert in pediatric emergency room medicine, pediatrics, and hospital administration. Additionally, she was offered as an expert in accepted standards of pediatric nursing care. These qualifications are based on her education, training and experience. The Special Grand Jury found her testimony credible.

Dr. Foster was called to the Special Grand Jury to offer her opinions around two broad categories. First, she was asked to render opinions around the care that was provided to the infants who were the subject of the 2023 Joint Investigation. Second, she was asked to offer opinions with respect to malice. Additionally, she was asked to provide opinions regarding the training that Strotman received and its adequacy.

Dr. Foster began her testimony by explaining the difference between accidental and non-accidental fractures. In practice, one of the first things to be considered in this determination is the mobility of the subject child. For a child who is non-mobile, the concern centers around what could have generated a significant enough force to cause the observed injury. The concern is that the force had to be externally applied instead of being created by the child itself. Dr. Foster also commented that there are certain types of fractures that are more concerning by their nature. She noted that one that is almost always associated with abuse is the type of fracture called a bucket or corner fracture. She also commented that rib fractures are also fractures that can be highly concerning for abuse. Fractures of infants in the NICU are unusually concerning because those children are almost completely immobile.

Dr. Foster was originally consulted in 2023 by Sgt. Fitzer and Sarah Wilson as part of the 2023 Joint Investigation. At the conclusion of that investigation, Dr. Foster eventually participated in the creation of a video to educate the personnel working in the HDH NICU about the child abuse and neglect and reporting requirements of mandatory reporters.

Dr. Foster commented regarding the presence of bruising and swelling in the context of an acute fracture in the NICU. Dr. Foster began her testimony with respect to this section by pointing out how exceedingly rare fractures in the NICU are: it happens one percent of the time in Level IV NICUs. Level IV NICUs are the NICUs that deal with the sickest infants, and for every 100 babies, one of them will have a single fracture every year. VCU is the only Level IV NICU in central Virginia. Of the very few fractures that happen every year, about a third are related to the birth process. According to Dr. Foster, if there is ever a fracture in the NICU, it should be thoroughly investigated until the cause of the fracture is fully ascertained. The child's metabolic health and accompanying bone strength and health are always of particular interest in the NICU

infant with a fracture. The metabolic health and overall picture must be reviewed as carefully as the bone imaging. To determine the cause of the fracture, the child abuse physician is reviewing the metabolic health, the radiological studies, and the offered history to try to determine what happened. The offered history is helpful in identifying the risk factors that need to be considered. Dr. Foster also emphasized the need for the skeletal survey, which is a series of about 22 low dose films to determine if there are any other broken bones. The skeletal survey allows reviewing physicians to see high-risk fractures that can frequently be clinically silent.

Dr. Foster also emphasized the requirements of mandatory reporting. Dr. Foster's Clinical Protection Team calls CPS every time that they have an injury that remains without medical explanation once the team has completed its evaluation. Dr. Foster told the Special Grand Jurors that the Code of Virginia requires that CPS is notified when there is concern for child abuse. Dr. Foster would not make a distinction if she thought an injury occurred inside her institution or outside her institution.

As Dr. Foster continued her testimony, she emphasized the rarity of these types of injuries and the work that is required to determine whether the injury is accidental or non-accidental. When she is conducting an analysis for a non-mobile infant, she is looking for a balance of risk factors. She is searching for evidence that the child has significant metabolic bone disease, and if the numbers are consistent with increasing the risk of that child's fracture occurring and the child has a single fracture, that's generally consistent with accidental injury, especially if at the time of the fracture there is a procedure that is related to it, generally something that required the manipulation of the child. Common places on the body for the presence of these very rare post-birth fractures are in the lower extremities whereas birth injuries are usually of the upper extremities or the clavicle. In Dr. Foster's over 35-year career at VCU, she has seen a single-fracture injury of a

NICU child three times. She has never seen a multi-fracture injury from the NICU ever in her career. Despite her national recognition as one of the preeminent authorities on the subject of child abuse and non-accidental fractures, and despite Dr. Reece's opinion, HDH never reached out to Dr. Foster to seek a consultation, although Dr. Foster is well known for consulting with other institutions and pediatricians who are dealing with complex issues related to child abuse and injury patterns. This is perplexing in the context of the 2024 Joint Investigation because HDH was specifically aware of Dr. Foster's involvement in the 2023 Joint Investigation. Dr. Foster was also the physician who was retained to offer education and professional development regarding child abuse and reporting requirements to HDH as part of HDH's agreement with the Commonwealth's Attorney's Office at the conclusion of the 2023 Joint Investigation.

In 2023, Dr. Foster offered the opinion that the cluster of injuries observed in 2023 was concerning for non-accidental trauma, based on her review of the medicine and the offered medical records. She was able to complete a differential diagnosis and eliminated other causes for these injuries, like osteogenesis imperfecta, rickets, and Vitamin D deficiencies. Moreover, when evaluating a hundred percent of fractures in children, three percent or less are secondary to metabolic bone disease. Most are secondary to trauma.

In the NICU population, there is an additional category of bone disease: osteopenia of prematurity. If a child is born very early, so less than 28 weeks, or has a very low birth weight, they typically have the risk factors that are concerning and their bones can be more prone to fracture. Nevertheless, even in the context of osteopenia of prematurity, these children are not expected to have fractures with no explanation. They may have a single fracture associated with a recent procedure but it is unexpected to see multiple fractures. Of note is that fractures may not be noted acutely if there is no deformity of the extremity. Fractures may not be found until

someone takes an x-ray for other purposes and sees a healing fracture on the film. Dr. Foster is unaware of the existence of any non-accidental fractures during her entire tenure at VCU. Dr. Foster believes that care in the NICU should be highly specialized, and nurses should only be allowed to provide it independently if they have been precepted by people who have been doing it for a long time. Dr. Foster pointed out that there is a nursing shortage like "this country has never seen before" post-COVID. Dr. Foster testified that some of the video footage of Strotman showed Strotman engaged in behavior that she has never seen before in the NICU.

In 2024, Dr. Foster was asked to assist in the 2023 Joint Investigation. At that point, Dr. Foster had guidance from the body of academic literature related to metabolic bone disease in pre-term infants. The literature is clear about the risk factors for metabolic bone disease: born before 28 weeks, less than 1500 grams, if the child has been on IV nutrition instead of using the gut for nutrition, if the child has been on a course of steroids, or a course of loop diuretics. Neuromuscular disorder also increases the risk factors for metabolic bone disease. The diagnosis of osteopenia of prematurity is an alkaline phosphatase reading of 700-750 or higher. Once that number is greater than 900 and the phosphorus number drops to less than 1.8, then 100 percent of those babies have a diagnosis of metabolic bone disease. There are medical interventions that can be made to avoid osteopenia of prematurity. The real risk of osteopenia of prematurity is that the bones won't be properly mineralized. The concern is that the bones are more vulnerable to damage with less force, but those bones don't just spontaneously break. There must be some exogenous force for that to happen. There are appropriate ways to handle and bundle those children so there is no injury to those children. For example, during Dr. Foster's tenure, VCU's NICU has not had a patient with multiple fractures.

In preparation for evaluation of the results of the 2023 Joint Investigation, Dr. Foster

reviewed a report from Children's Hospital of Philadelphia published in 2021. It was a retrospective study and looked back over a five-year period at 5,656 babies. They found 28 birth related fractures, and 57 fractures that were not birth related. Although this study was only an extremity fracture study, this study showed that the babies who had the 57 fractures had known risk fractures and they had recent bedside procedures. The children who got the fractures had very high alkaline phosphatase levels and very low phosphorous levels. 85 percent of these babies had been on a ventilator, and the average time on a ventilator was 43 days, so these were very sick babies. 64 percent of them were on diuretics and 75 percent of them had been on TPN. At the time of fractures, 60 percent of them were still TPN. Dr. Foster highlighted this study because fractures in this context are so rare, and this study shows that this kind of fracture happens to less than one percent of the very sickest children. For one third of these children, the single fractures were related to birth injuries and the two thirds of the children who got fractures were very ill and had the risk factors for these injuries. What this showed Dr. Foster is that while these injuries do happen, they are typically single-fracture injury patterns for the very sickest of NICU babies.

When Dr. Foster was consulted in 2023, she was given a complete medical record for each of the 4 subject children she was asked to review. She also received a document from Dr. Reece, who she respects very much, entitled "Windows of Opportunity." The fact that Dr. Reece had concerns for non-accidental trauma was alarming to Dr. Foster, because of her respect for his abilities as a physician. In 2023, there was no offered history to explain the observed injuries, nor was there any video evidence.

The first 2023 baby whose records Dr. Foster reviewed was very pre-term and weighed about a pound. The first fracture, which was a broken arm, was found when the baby was four days old. It was a significant midshaft break of both the right radius and ulna that would have

required significant tractional force. About 10 days later, they find a left femur fracture on this same baby. The femur is a large bone that is difficult to break. Ultimately, another fracture is located on this baby's right lateral sixth rib. Additionally, two additional rib fractures were found on this child, one on the right third rib and one on the right fifth rib. They also found a fracture of the left radius. There was also a concern for a fourth rib fracture on the right eighth rib, as well. There was nothing in the medical record to support a finding that this rib was broken during the process of providing CPR to this baby. Dr. Foster was concerned about the fact that there were several fractures of varying ages observed on this child, which demonstrates that there is repetitive interaction and external forces being placed on the child that is incurring these injuries.

Dr. Foster believes that HDH should have been concerned because there were so many fractures and the involvement of ribs and long bones in a completely immobile child. Moreover, the caretakers in both orthopedics and radiology were discussing non-accidental trauma in the medical records. Additionally, on September 17, 2023, the medical records show that there was a progress note that documents bruising on the neck and upper chest wall of that infant by an evaluating pediatric surgeon. It is unusual and concerning for an infant of that age to have bruising on the chest wall.

Dr. Foster reviewed this first child's numbers to evaluate risk factors for metabolic bone disease that would make this baby more susceptible to bone breakage. The alkaline phosphatase was borderline, but not so high as to make a definitive diagnosis of osteopenia of prematurity. Dr. Foster also pointed out that one of the things that causes an increase in alkaline phosphatase is a fracture, so the observed breaks may have been what raised the alkaline phosphatase, but it still never got past the 500 range. This child received enteral feeds during all of this, which meant that the risk factor of being on TPN did not exist. All things considered, this child was doing pretty

well for having been born so small.

Dr. Foster also noted a break in the skin above the ankle that required two stitches to repair. She commented that in order for the skin to be opened like this, there would have had to be some kind of tractional pull. There was also a smaller wound symmetrically on the other side that did not require stitches. Ordinarily, these wounds would only be seen as part of the birthing process, but these injuries didn't present until a week after birth.

The second 2023 baby was born on August 25, 2023. He was born at 28 weeks and 6 days, so he was a third trimester baby who weighed 2.2 pounds at delivery. This child did not have risk factors for metabolic bone disease: he was more than 28 weeks gestation, weighed more than 1500 grams at time of injury, and was only TPN for a single day.

His left leg was initially x-rayed on September 6, 2023 because he wasn't moving it the same way he was moving his right leg. He was increasingly fussy as well. The x-ray showed that on the medial side of his left distal tibia, right above the ankle, he had a classic bucket handle fracture where a piece of the bone at that joint space had been pulled off in the shape of a bucket handle. On the lateral side, a small corner had been pulled off. Essentially, this fracture extended across the entire growth place of that bone. Bucket handle fractures are the most pathognomonic for abuse because they don't happen in accidental scenarios because of the kind of force they require. This child had had a previous x-ray and this fracture had not been observed on this day.

This child's numbers for calcium, phosphorous, and alkaline phosphatase were all in normal limits. This child did not have osteopenia of prematurity. Dr. Foster also reviewed a report from Dr. Aarons, who reviewed the first x-ray and recommended a skeletal survey when he was consulted on September 6, 2023. Dr. Foster commented that the alkaline phosphatase, which always was in normal limits, was higher the day after the fracture was diagnosed than prior to the

fracture, when it is a really good low number.

Dr. Foster recounted her review of the records related to the third baby she reviewed. This child was born on June 19, 2023 at 25 weeks and three days, and weighed about 2.3 pounds but had decent APGAR scores at birth. APGAR scores reflect how well a child is doing at time of birth. A 7 and an 8 are good scores.

Bruising was noted on this child on September 5, 2023, several months after this baby is born. In response to concerns raised by the staff about the bruising, a bone survey was conducted to evaluate this child for injury. This third child had an irregularity at the distal left radius, with periosteal reaction around the distal part of the radius. They also found an irregularity to the ulna, right above the wrist. A periosteal reaction means that the body is reacting to the task of fixing the broken bone. Usually the periosteal reaction is visible on screenings somewhere between 3 and 7 days after the acute injury, with the caveat that the younger the child, the faster the child is to heal. The investigatory benefit of the periosteal reaction is it allows reviewers to age an injury, but the aging can only be determined in a general range. When subsequent imaging is done on this on September 6, 2023, the reviewing physicians say that the injury is most consistent with a buckle fracture. Buckle fractures are fractures that come from compression forces and the bone "buckles" under the compression force. Instead of breaking, the bone literally compresses and buckles in on itself. The concern regarding a buckle fracture for abuse for a non-mobile NICU infant is that there would have had to be compression force on both sides of the bone in order for it to crumple.

Dr. Foster looked at this child's alkaline phosphatase which was totally normal at the time of the fractures. In July, over two months before this child was injured, the child had an alkaline phosphatase of only 285, well within normal limits. This was a child who was not ventilator

dependent and who was enterally fed. This child was on a diuretic but not a loop diuretic, so that should not have been a concern. On the day this fracture was reported, this was a relatively large baby, weighing nearly 6 pounds. This child did need care from a pediatric endocrinologist, and that care was not available at HDH's NICU, so this child was transferred to Children's National for the management of that deficiency, but not for any reason related to bone health.

The fourth baby from the 2023 Joint Investigation was born on July 29, 2023, and was 31 weeks and 4 days, making him the oldest of the group at the time of birth. He was not heavy for his gestational age at birth at not quite three pounds. The reason this baby was small for his age is that his mother developed hypertension and high blood pressure and that in turn affected his ability to grow in utero. The risk of intrauterine growth retardation in the context of metabolic bone health is that there is less than normal alkaline phosphatase transfer from mom to baby. This was this baby's sole risk factor for compromised metabolic bone health.

This child was scanned for fractures at birth and didn't have any. His fracture, a massive transverse fracture to the left radius that displaces the bone by an entire bone length, showed up on a babygram for the first time on August 5, 2023. This was incorrectly coded as a birth injury, but Dr. Foster's review of the records demonstrates that this is an error. Reviewing orthopedists from HDH agreed with Dr. Foster and they were highly concerned about this fracture because of the level of displacement. It is very unusual to have full shaft displacement, which is what this child had. Additionally, in follow up studies, it was confirmed that the left ulna was also fractured, although this fracture was a tiny step-off fracture, not a massive one like the one viewed on the radius. HDH did not conduct a skeletal survey of this child; instead, they did more limited reviews. This was the child who was discharged before CPS was ever notified that there was a problem, as CPS wasn't notified until about 10 days later of the concern regarding this cluster of fractures.

This child initially needed TPN but quickly advanced to regular feeds. This child did not need a ventilator. He needed extra glucose but was getting full feeds to the gut which is the most important part in terms of reducing risk for metabolic bone disease. It is Dr. Foster's opinion that this child did not have Osteopenia of Prematurity.

HDH's belief that these injuries occurred spontaneously because of osteopenia of prematurity is wrong. Two of the four 2023 babies did not have it at all, and the other two just had increased risk factors, but their labs never rose high enough to constitute a formal diagnosis of Osteopenia of Prematurity. Dr. Foster was not prepared to say to a degree of medical certainty that she could exclude osteopenia of premature as a causation of any of those small, preterm infants' fractures but she also said that they did not align with the characteristic findings of those in terms of the treatment risk that they had or in terms of the numbers that their bones were showing when labs were drawn. In fact, the one child with an elevated alkaline phosphatase was the one with the massive number of fractures.

Dr. Foster also rejected the hospital's assertion that osteopenia of prematurity, itself, does 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 NICU 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 510 gram infant born at 23 weeks, she couldn't 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 infant, it was her opinion was the number of fractures and the constellation of findings being 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 describes 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 the 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 2024 Baby No. 1 could have caused this observed injury.

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 that nurses who were employed by VCU. There was nothing in the record that suggests that Strotman was improperly trained.

Dr. Foster then testified about the injuries to 2024 Joint Investigation Baby No. 1. 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 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.

This concluded Dr. Foster's testimony.

Exhibit L: Glossary of Terms

Alkaline Phosphatase: is an enzyme that's found throughout your body. ALP blood tests measure the level of ALP in your blood that comes from your liver and bones, and it's one of the tests included in a comprehensive metabolic panel. High levels of ALP in your blood may indicate liver disease or certain bone disorders.

Alprazolam: a prescription medication belonging to the benzodiazepine class of central nervous system depressants. It is primarily used to treat anxiety disorders and panic disorders. It is the generic name for the brand-name drug Xanax.

APGAR score: quick assessment used to evaluate the health of a newborn baby immediately after birth.

Bucket Handle or Bucket Fracture: a bucket handle fracture (also known as a metaphyseal corner fracture or classic metaphyseal lesion) is a specific type of bone injury highly suggestive of child abuse in infants and young children.

Buckle Fracture: are caused by axial loading on an extended extremity. While buckle fractures are most commonly caused by accidental falls, they are considered suspicious for abuse when there is a lack of a clear, verifiable accidental history, particularly in infants, or when accompanied by other signs of abuse like a delay in seeking medical care, multiple fractures in different stages of healing, or a history that is inconsistent with the injury.

Enteral Feeds: delivers liquid nutrition through a flexible tube that goes in through the nose or directly into the stomach or small intestine.

Femur: the longest, strongest, and heaviest bone in the human body. It is located in the upper leg, extending from the hip to the knee.

Metabolic Bone Health: refers to the processes that govern bone strength and density, including bone formation and breakdown. To maintain healthy bones, it is important to consume a diet rich in calcium, vitamin D, and protein, and to engage in regular weight-bearing exercise. A variety of factors, including genetic conditions, hormonal imbalances, and deficiencies, can negatively affect metabolic bone health and lead to disorders like osteoporosis or rickets.

Metacarpal: one of the five long bones in the palm of your hand that connects the wrist bones (carpal bones) to the finger bones (phalanges).

Metaphyseal Fracture: is a bone fracture that occurs in the metaphysis, the wider part of a long bone located near the growth plate.

Osteopenia of Prematurity: a condition that affects premature infants, characterized by low bone mineral density and an increased risk of fractures.

Pathognomonic: specifically characteristic or indicative of a particular disease or condition.

Periosteal reaction: refers to a thickening and elevation of the periosteum, the outer layer of bone, in response to an underlying insult.

Radius: one of the two long bones in the forearm, located on the thumb side. It extends from the elbow to the wrist joint.

SSRI: a class of medications used to treat depression, anxiety, and other mental health conditions. They work by increasing the levels of serotonin in the brain, a neurotransmitter that plays a role in mood regulation.

TPN: is the acronym for Total Parenteral Nutrition, a method of providing essential nutrients directly into the bloodstream via an intravenous (IV) line, bypassing the digestive system. It is used for people who cannot get adequate nutrition from eating or drinking, or whose digestive system is unable to absorb nutrients properly. The TPN solution includes a balance of carbohydrates, proteins, fats, vitamins, minerals, and water.

Ulna: the thinner and longer of the two bones in the human forearm, on the side opposite to the thumb.

Exhibit M: Glossary of Terms