Case Narrative – 14C101622 Det. Lt. James Cruise

Incident:

This case documents the review of all files in the Investigation into broken legs to a 1 year old child. The case review is to see if any actions or inactions on the part of any public official involved rise to the level of Criminal Neglect.

Exhibits/ Evidence:

1. Case files received from DCF to include the following:
    - Initial Case file with
        - Case plans
        - Case worker notes
        - Court-CHINS file
        - Custody case task list
        - Extra file inserts
        - Investigation
        - Medical information
        - Releases
    - Court Records
    - Substantiation Appeal file
    - Case Plans
    - Additional DCF intake reports
    - Affidavit of [Detective 3]
    - Assorted single page attachments
    - DCF Contact notes
    - DCF Policies
    - Eckerd Reports
    - Family Court Transcripts
    - Medical Records from Vermont Childrens Hospital
    - Medical Records from DHMC dated 2-25-14
    - [Foster Mother and Foster Father] foster care application
    - Rutland PD file obtained by Rutland PD
    - Rutland PD file received by Lt. Cruise
    - Safety Assessment of 2-14-13
    - Substantiation review report

2. Case file received from Rutland City Police
3. Digital interview of [DS's Attorney]

4. Copy of the marriage certificate of Sandra Eastman and Dennis Duby
5. Digital interview of [Foster Mother and Foster Father]
6. Digital interview of [Family Member 1]
7. Digital interview of [DCF1]
8. Digital interview of [DCF3]
9. Digital interview of [DCF2]
10. Digital interview of [DCF4]

Persons of Interest/ Interviewed:

[DS's Attorney]

[Family Member 1]

[Foster Mother]

[Foster Father]

[DCF3]

[DCF1]

[DCF2]

[State's Attorney's Office]

[DCF4]

Narrative:

1. On 17 March 2014 I met with Capt. Jean Paul Sinclair in regards to being assigned an investigation into the initial child abuse case against Juvenile DS, whose recent death was being investigated as a homicide. The initial case

involved her being brought into the hospital with broken legs on 14 Feb 2013, at age 1. At this time I was informed by both he and Commissioner Flynn that there were records already at the Department of Human Resources and that additional records could be obtained directly from DCF headquarters in Essex and that States Attorney Mark Brierre had also agreed to allow access to his office's records in the handling of the CHINS case after the broken legs allegation.

2. On 18 March 2014 I met with Dan Cavanaugh and Steve Collier of the State of Vermont department of Human resources. During this meeting I was made aware that after the death of DS, DCF sent a notice to several employees that they would be interviewed in connection with the review of the original case. I was then informed that 2 of the interviews were done after being given Garrity Warnings and a third worker, [DCF2], provided an interview without being issued her Garrity warnings. I was then given a package of files that was sealed and to be reviewed by legal counsel for the Vermont State Police. I was also advised that they were still waiting on files from the Department of Corrections in connection with this case as well.

3. I subsequently spoke with Attorney Matt Levine of the Attorney General's office. (He had been assigned to this case) It was subsequently decided that I would keep this envelope sealed and seek to independently obtain the case files from the various sources.

4. On 18 March 2014 I made contact with States Attorney Mark Brierre. In the ensuing conversation I asked about being able to copy his files in this case. He now explained that DCF would have the same files and he saw no need to allow access to his files at this time.

5. On 20 March 2014 I made contact with Cindy Wolcott, Deputy Commissioner of the Department of Children and Families (DCF). During the ensuing conversation she explained that after the initial injury they now have 2 investigations going. We discussed that I was aware of her having [Rutland PD2] looking back into the broken legs case. She agreed to have this investigation suspended until such time as we could conduct our review into any criminal neglect. She then advised that she would ensure that [DCF Director] had copied all files that I would need and would be available to meet the follow day for me to receive these case files.

6. I subsequently received a phone call from assigned counsel for DCF from Linda Purdy. She advised that we could meet at 1300 hrs. on 21 March 2014 to get the case files.

7. On 21 March 2014 at 1300 hrs I traveled to DCF main offices in Essex Vermont and met with [DCF Director] and Linda Purdy. During the ensuing conversation I was informed that the files from the Department of Corrections had been redacted from this set of files. I was also informed that the 3 primary DCF workers involved were [DCF1, DCF3 and DCF2]. I was informed that they had been interviewed already and I requested to specifically not be told of any details of any prior interviews in this case. (This was due to the Garritty warning issue involved in internal investigations, precluding that testimony from use in any potential criminal investigation.) I was informed that the child, DS, came into custody on 14 Feb 2013 and that she had been placed back with her mother, prior to her death. I was also advised that [Eckerd Worker] was the Eckerd worker who monitored most of the family visits and parenting coaching. I was also given the 3 case plans in this investigation. [DCF Director] went over each of the major files and provided me with the details of each section. I was also given copies of several internal DCF policies that both [DCF Director] and Linda Purdy thought may be applicable. I was informed that the attorney for DS was DS's attorney and that the Guardian ad Litem was [Guardian Ad Litem.] It was also pointed out to me that policy 125 was the policy in regards to re-unification of the child with the parent. The files I received were approximately ¾ of a bankers box of files and materials. (These files have since been scanned into PDF format for easier storage and inclusion with case reports.)

8. I subsequently began a review of all the case files I had been provided. (I had already viewed the Rutland Police case in the state RMS (Records Management System)) This review became the basis for later questions developed during several of the interviews in connection with this investigation. The results of this review and the findings noted will be discussed at the end of this report, as it will also contain any possible explanations from interviews as well.

9. On 26 March 2014 I began to attempt to reach [DS's Attorney], the attorney assigned to DS for the CHINS and initial case. In speaking with her on the phone she advised that she was never aware of the actual plea deal in criminal court and has assumed that Sandra Eastman took responsibility for the broken legs. I informed her that this was not the case and that she only pled out to medical neglect. I then asked her if she was ever made aware of Dennis Duby being in the

life of Sandra Eastman and DS at the time of the broken legs, and she advised that she was not aware of this as well. We then arranged to meet in person to discuss the case much further.

10. On 31 March 2014 I met with [DS's Attorney] at the State Police Office of Professional Development in Pittsford. I subsequently spoke with her at length about this investigation, and after a time we recapped the interview in a sworn taped interview.

11. During the ensuing conversation she advised that during her representation of DS she had never had any interaction with Sandra Eastman prior to this case. She went on to advise that she was assigned as legal representative for DS and that [Guardian Ad Litem] was appointed by the court as Guardian ad Litem for DS. She then advised that [Eastman Attorney] was assigned counsel for Sandra Eastman. She then advised that in general she takes her lead off the Guardian ad Lite in these cases as the children are not able to communicate their wishes. She advised that with older children she will seek their input to some extent as well.

12. I then asked about information and paperwork flow in this case and she advised that she is only provided with the court referral packet initially and this contains little more than the affidavit for the CHINS process. She advised that in this case she requested the medical packet from [State's Attorney's Office]. She advised that she was given the initial medical info from Rutland but she never received the report and assessment of [Doctor].

13. I then asked about whether she was ever made aware of Dennis Duby being in the picture, especially at the beginning of the case. She advised that she was never made aware of him. I then asked if this knowledge would have changed anything in her representation and she advised that it could have and that he would have been identified and in plans.

14. I then asked her if she had ever been made aware of the allegation of facial bruising to DS, about 10 days prior to the broken legs incident and she advised that she was not aware of this, nor was she ever given any information about this.

15. I then asked if she was ever made aware of Dennis Duby living there or the marriage and she advised that she was not and had only recently learned of the marriage and found out it happened in May of 2013. She then advised that he was never addressed in any of the DCF case plans or within the disposition reports.

16. I then asked if she had ever been made aware of any possible mental health issues with Sandra Eastman and she advised that she had not and was not certain that any mental health examination or screening had been completed on her in this case.

17. I then asked if she had ever met with or heard any information from the foster parents in this case. She advised that she never had contact with them and was not made aware of any information from them. I then asked her if she had ever been specifically made aware that Sandra Eastman told the foster parents that she lied to the police in her interview and had to just say something as she thought DS was going to be taken away and that Sandra advised that she didn't know how it happened and had to come up with something. [DS's Attorney] advised that this is information she was never aware of and that with this information, she would have at least changed the wording in the merits stipulation hearing of 3-21-13.

18. She advised that given this information she would have insisted that Dennis Duby be part of the planning at the very least. She went on to advise that she had a copy of the marriage certificate and provided this to me (see file copy) and that she was never aware of this at the time. She also advised that she was never informed by DCF that DS had been placed back into the home, and only found this out much later. She advised that she recalled [DCF3] was out for a time during this case.

19. [DS's Attorney] then advised that she was never aware of the Substantiation Appeal hearing and that the testimony of Sandra Eastman was so different from what they had already known. She advised that she only found this out recently as she had been researching the case more since the death and was shocked to find out how much she was never informed about in this case.

20. At approximately 1101 hrs I then began a taped interview with [DS's Attorney]. (See the actual recoding for exact details.) The following is a summary of the taped portion of the interview with [DS's Attorney]:

21. She advised that she was assigned via the Defender General's office and the Guardian ad Litem. She again re-iterated the little information she initially received and the request for the medical information which would have been received at the pre-trial conference. She advised she never saw the files and report of [Doctor].

22. She advised the limited information she had was from the affidavit of [Detective] and was never aware of Dennis Duby's name coming up in the investigation, or of

the marriage. She advised Dennis Duby was never part of the planning or the case. She advised that timing of the injuries made it difficult to prove who did it and that Sandra was denying the involvement in breaking her legs. She advised that Sandra never admitted involvement with the injuries of DS in any court context.

23. We then re-iterated the allegation of the facial bruising prior to the broken legs.

24. She advised that she was surprised that she was not provided more information from DCF in this case especially given their knowledge of Dennis Duby being in the picture and the additional allegations. She would have expected him to be in the planning by DCF at the very least and he was not.

25. She then advised that she only recently found out about the marriage. She advised that if she had known of this then, she would have at least asked why he wasn't involved in the planning. She advised that he should have been required to be part of the process.

26. We then discussed the foster parents and the placement. She advised that she did not speak with them and was never aware of the comments to them by Sandra Eastman. She advised she did not recall those comments. She also advised that it is difficult to test the veracity of information provided by family members.

27. She advised that [DCF3] was out for several of the hearings and that several other DCF workers came into play covering some of the hearings and planning.

28. She advised that she never was made aware that DS was placed back into the home in October of 2013. She advised they used to get notified as to placement movement and that has not happened for several years.

29. She advised that she was never aware of the substantiation appeal by Sandra Eastman. She advised that she has since seen the hearing notes and that she only was responsible for the medical neglect and was blaming Dennis Duby for dropping DS or breaking her legs. She advised that it doesn't go into detail but indicates Dennis Duby was in some way responsible.

30. She advised that in hindsight, knowing about the marriage and possible involvement in the injuries to DS, she would have seriously questioned why Dennis Duby wasn't in the planning process and involved. She advised this was common and should have been addressed. She advised that it was a reasonable bet

that reunification would have likely taken longer and may not have occurred if this information had been known to her.

31. This ended my interview with [DS's Attorney] (see the digital interview for more detail).

32. On 1 April 2014 I received a call from [DS's Attorney]. At that time she advised that she had learned that [Eckerd Worker], who was the family/parenting coach for Sandra Eastman had been put on admin leave and had since left Eckerd services.

33. On 2 April 2014 I met with Assistant Attorney General Matthew Levine to discuss the case and future interviews. After this discussion about the case progression it was agreed that I would go direct with the subjects to be interviewed to get these arranged.

34. On 7 April 2014 I met briefly with [State's Attorney's Office] while at the Rutland District Court. I had previously called him at his office in an attempt to arrange an interview regarding this investigation. During the brief conversation I explained to him the case and asked if he recalled the case and what he knew about the facts of the case while it was progressing. In conversation I asked him if he was ever made aware that Dennis Duby was living in the home during the CHINS case and he advised that he was never aware of that at the time the case was in court and prior to the re-unification. I then asked him if he had ever been made aware of any allegation of facial bruising prior to the broken legs and of any conversation [DCF1] had with Dennis Duby regarding that allegation. He advised that he had never been made aware of these details either. I asked him what information he was relying on to form the court plan and he advised that he relied on the investigators to tell him what was happening and who may be involved. He then advised that if he had been made aware of these details and Dennis Duby being in the home, he would have asked to have him included in the case plan all along. Due to an arraignment we were attending we were unable to converse further at this time.
35. On 8 April 2014 I contacted Linda Purdy to discuss a note I had discovered within the case file review. This was a note regarding a Reach Up note of 6-4-13 regarding a possible mental health examination for Sandra Eastman. I also inquired about the 2 different versions of the intake form that I had found within the case files. In response to these questions I learned that I would not be able to access the Reach Up files without a subpoena. I also learned that the different

versions of the intake were due to new information be appended to the intake over time and printed at different times.

36. On 8 April 2014 I spoke with [Hearing Officer] the hearing officer for the Substantiation Appeal by Sandra Eastman. In conversation with him he advised that the appeal would have been filed about 15 days prior to the hearing and that the burden is on the person appealing to present their case for the overturn of the appeal. He advised that he gets a limited copy of the actual case files from DCF. He also recalled that she testified that she had lied to [Detective] and that she advised she was not involved in breaking the legs of DS but had to say something. He further advised that she did not acknowledge any mental health issues or defense.

37. On 9 April 2014 I began looking to meet with [Family Member 1 and Family Member 2]. I stopped at their home in Fair Haven and was informed that she was out of state at this time. I then received a phone call back and spoke with [Family Member 1] and arranged to meet the following day to interview her. She also advised that she had never been interviewed by anyone after she made the report to DCF on the facial bruising.

38. On 9 April 2014 I was able to make contact with [Former DCF] by phone. [Former DCF] had since retired and had been the supervisor in charge of investigations at the time of this case. I explained why I was seeking to speak with him and asked him if he could recall the case. He advised that he did not recall a lot of the particulars but did supervise [DCF1] at the time. He advised that after the investigation portion was complete he did not stay up to date on the case as it had been passed over to the Case Worker. I asked if he had any recollection of an allegation of facial bruising prior to the broken legs incident and he advised that he did not. He further advised that he was aware that [DCF3] was out for some of the time of this case and that in DCF the push is very strong for re-unification in these cases. I then asked if he ever recalled this case being staffed in house to review the case or any issues and he advised that he did not recall this case ever being staffed in house.

39. On 9 April 2014 at approximately 1928 hrs I met with and conducted an interview of [Foster Mother and Foster Father]. This was at their residence in Chester and was a digitally recorded interview. The following narrative is a synopsis of that interview: (For more details see thee digital interview – the interview was taped in 2 parts due to the tape stopping after the first part))

40. I had first explained why I was there and wished to speak with them. I then asked about how they came to be involved in the DS case. She advised that this case actually started when Sandra thought DS's club foot was acting up again, and took her to the hospital. She advised that had been posted on Facebook and when she called Sandra on this she was informed that DCF had taken the child away. [Identifying information removed.] Sandra told her that she had been found to have broken legs and that if she didn't come up with a story as to how it happened they would take the child away from her.

41. They then became the foster parents and did this as soon as they could after they found out she had been taken away.

42. They advised that they primarily interacted with [DCF3] of DCF. I then asked about a note with comments they had allegedly from Sandra. [Foster Mother] advised that Sandra had told her she thought there were demons at her house and DS was going to fly down the stairs. She then advised that Sandra told her that Dennis had dropped DS in the pack and play and DS had struck her head. She then advised that she had to come up with some story about what happened or she wouldn't be able to see DS. She advised that Sandra had told her that she thought the broken legs happened at her mother's house. [Foster Mother] advised that she shared this information with [DCF3].

43. They advised they did have contact with [DCF1] and that she had come to the house and had told her and a [full name unknown] when they came to do the home inspection. They advised they had never spoken to anyone in law enforcement about this. She also advised that DCF never asked or followed up on this information after this time.

44. [Foster Mother] advised that they would tell things to [DCF3] after the visits and DS would wake up with night screams and that [DCF3] told them this was normal. [Foster Father] advised that they finally got the visitations to be moved to the Springfield area as DS was always getting car sick. They advised that DCF then got [Eckerd Worker] involved and began to facilitate the visits in this area. They advised they brought up to both [DCF3 and Eckerd Worker] several issues with DS and they were told it was all normal. [Foster Father] then related how when [Eckerd Worker] and Sandra went to the day care to get DS the first time, DS went to [Eckerd Worker] and avoided Sandra. He advised that he found this to be odd that she would go to a stranger and not to her mother. I then asked about any bruises she had after any visits and they advised that they could not recall seeing any.

45. I then asked about another issue they brought up to [DCF3]. They both advised that they were discouraged from bringing up issues and that [DCF3] told them that if DS showed up with a bruise it was normal as children would fall etc and they did not have to report this. They were then advised that they did not need to go fishing for information and to not hinder the process of working toward getting DS back with her mother. They advised that they were told repeatedly by [DCF3] that in the state of Vermont, any child under 5 they were mandated to do everything they possibly could to send the child home. [Foster Mother] advised that this was in contrast to what they were told about potential adoption.

46. They advised they were told that everything would be done in 6 month blocks.

47. They advised they knew Dennis Duby was in the picture when the legs were broken. They advised that they did not tell anyone with DCF about this at the time, but may have at least informed one of the workers that Sandra was dating Dennis Duby. She recalled the time Sandra told her of Dennis Duby dropping DS into the pack and play and bumped her head. She advised that this was also related to [Family Member 1] as well. [Family Member 1] asked Sandra about what happened to her and Sandy told her that Dennis dropped her. She advised that [Family Member 1] told her that Sandra covered it up with make up at the time.

48. I then asked about when they were placing DS back in the home. [Foster Father] advised this was a joke as they were told they would be at her house or home. They advised that they felt that DCF got sick of coming all the way over to Springfield for the visits and then were setting up to put DS with a couple in Clarendon. [Foster Mother] advised that this was because they wouldn't do what DCF wanted them to do, which was to bring DS to Rutland for the visits. They advised that at first they were informed that making the visits was up to Sandra and that she was supposed to go to Rutland and then [Eckerd Worker] would take her from there. This then ended up with [Eckerd Worker] getting her at her home in Poultney. They advised that they both work for a living.

49. They also advised that they had discussed getting a lawyer for DS and were told they could not do this.

50. I then asked about the process as they were made aware of it. They advised that they were told everything would be in 6 month increments, up to 3 blocks and a decision would be made to place her back or terminate her rights. They then

advised that at the 7 month mark, DCF was trying to arrange a placement with a family in Clarendon. They advised it was with 2 women and they advised that Sandra didn't want the placement as well. They advised that this switch was because they wanted her closer for more visitations. They also advised that DCF was counting the time that Sandra was together with [Eckerd Worker] as her parenting classes as well.

51. They then advised that for the return of DS they were just told that DS was to be returned to Sandra at her home with all her belongings. They did this on a Saturday and brought her back to Poultney to Sandra's house. They advised this was possibly in September. They advised that there were no DCF workers involved, and they met directly with Sandra at her house. They were told that DCF would then be checking up on DS and Sandra in the home. After this involvement and return of DS they never got any further updates from DCF but did speak with Sandra often about DS.

52. I then asked about their knowledge of Dennis Duby and Sandra and they advised that shortly after DS was taken away, Sandra got pregnant and Dennis moved in part time and they got married.

53. This ended the interview of [Foster Mother and Foster Father].(See Digital interview for more details)

54. On 10 April 2014 I met with [Family Member 1] at the Fair Haven Police Department. She is the wife of [Family Member 2], who is [identifying information removed]. I subsequently interviewed her regarding this investigation and her reports to DCF concerning this case. At this time she also provided me with the cell phone she had at the time, which contained the text messages she had received from Dennis Duby, concerning her questions to him. (Subsequent efforts to down load the content of the cell phone were unsuccessful so photo images of the screen shots were taken.) I subsequently conducted a taped interview of her at approximately 1620 hrs. The following is a synopsis of that interview:

55. She first advised that she did recall the case beginning in February of 2013. I then asked about her call to DCF and she advised that she called because she had gone over to Sandra's house and went to play with DS who was in her pack and play at the time and noticed a bruise on her face. She described the bruise as starting on the forehead and going all the way down to under the area of her cheekbone. She asked Sandra about this and was told that Dennis had dropped her into the pack and play. [Family Member 1] advised this did not make sense to her given the size

of the bruise. She advised that she had gone into the DCF office and spoke with someone, and advised this was about a week before DS was brought to the hospital for the broken legs. She advised that she spoke with a female who was short and had brown hair.

56. She advised that this bruise was far too big to be from the pack and play and advised that when she observed the pack and play it had the padding intact and looked fine. She advised the DCF worker told her they would look into it. She advised that about a week and a half later she received a call from a [Relative] of Sandra Eastman, telling her that DS was in the hospital with broken legs. She advised that after this she called into DCF with the same complaint and told them that she had texts from Dennis Duby as well as she had asked Duby about it via text.

57. When asked about the text thread between her and Duby over this issue she advised that she asked him what happened, about the legs. She advised that he didn't know and that Sandra had called him for a ride to the hospital. She then asked him about the pack and play and he advised that he did not drop her and that he would never touch that baby. She advised that she has since found out that he admitted to DCF that he dropped her into the pack and play.

58. I then asked her about the broken legs and she advised that she asked both Dennis and Sandy about this and that Dennis had advised he had been at work and Sandy called him to tell her that DS had a swollen leg and needed to go to the ER. He kept denying it and being involved.

59. I then asked her about the other comment about Sandra making up a story. She advised that she asked Sandra about how this happened and told her she needed the truth. Sandra told her that she didn't know how it happened. She advised Sandra then told that a DCF worker had come into the hospital and told her that she would not be getting her child back unless she came up with how her legs got broken. She advised Sandra then told the worker that she had dropped her, then that she had stopped her from going down the stairs and then another version of how it happened. I then asked about the demons comment and she advised that she knew of this but that Sandra had made that comment to [Relative 2]. [Family Member 1] advised that [Relative 2] had told her that Sandra called her crying saying that she thinks a demonic force had thrown DS down the stairs.

60. [Family Member 1] advised that she was never interviewed by DCF on this or by the Police and that she never got any letter from DCF on the report to them about this information.

61. [Family Member 1] advised that Dennis Duby came into the picture around December of 2012. She advised that the older child was having visits to Sandra and she and [Family Member 2] had asked to meet Dennis and they refused to do this, so she and [Family Member 2] stopped the visitation of Sandra's oldest child. She advised this was done about a month before the broken legs incident. She advised that Sandra never called [Family Member 2] or DCF over this stoppage of the visits.

62. She advised that she had never seen or met Dennis Duby.

63. [Family Member 1] advised that her biggest issue with this was that Sandra only got charged with the medical neglect and if they never knew who broke the child's legs how they could put her back in the home.

64. [Family Member 1] advised that she had been in to see [DCF3] because they were trying to arrange visits again for the older child. [DCF3] told her it was wrong to keep Sandra from the visits and that she had admitted she was wrong and gotten help and should have visits again. She advised they never resumed the visits.

65. [Family Member 1] advised that she could not understand how this could happen. She advised that in 2009 when [Family Member 2] got full custody from Sandra it was because DCF was involved and Sandra had been doing drugs in the house. She advised with the past incidents she could not see how DS was placed back into the house.

66. I then asked about anyone else seeing the bruise and she advised that possibly a visiting nurse would have seen the bruise. She advised that she had told DCF and her husband about seeing the bruise as well as [Relative]. She advised that she would give me the phone to take for this case.

67. This ended the taped interview with [Family Member 1] (see digital interview for more details)

68. On 14 April 2014 I began efforts to contact and interview [DCF2, DCF3 and DCF1], all of the Department of Children and Families Rutland office. In subsequent conversations with each of them, they all expressed their desire to

seek legal counsel. I subsequently received a call from the [Vermont State Employees Association] and advised that her office represents these workers and would like to have representation present for them prior to any interview. I subsequently spoke with [Attorney for DCF3 and DCF1] and arranged interviews of both of these workers. Additionally I spoke with [Attorney for DCF2], and arranged for her to be interviewed as well.

69. On 16 April 2014 I had arranged to meet with and interview, now retired, [Detective]. We met at the Rutland State Police barracks. I informed him of the nature of the investigation and that this was in fact a criminal inquiry and he advised that he would not interview without a lawyer and letter of immunity. No questions were asked of him concerning this investigation.

70. On 21 April 2014 I met with [DCF1] and her attorney, at the law office of [Attorney for DCF3 and 1] in Rutland Vermont. I then conducted a recorded, sworn taped interview of [DCF1] in the presence of her attorney. Subsequent to this I provided [Attorney] with a copy of this digital recorded interview. The following narrative is a synopsis of that interview: (For further detail review the digital recording of this interview)

71. I first went over the voluntary nature of the interview and that she had time to consult to her attorney prior to consenting to this interview.

72. I first asked her how she became involved in the investigation and what she recalled of this. She advised that a report was made to their central intake and assigned to her by [Former DCF]. She advised that she responded to the hospital right away that day. She advised that CFAC (Child First Advocacy Center) was notified and they advised to screen at the hospital and see if they would be needed. She went to the hospital and met with a nurse and doctor and got some details of the injuries. They explained that DS had come in with her mother, Sandra and that there was no real explanation by her for the broken legs. She advised that she went into the room and that DS, Sandra Eastman and Dennis Duby were all in the room together at that time. She advised that she asked Sandra for her side of the story and got that she really didn't know what had happened and that she had asked Dennis to drive them to the hospital, because she knew DS was in pain and was no longer crawling. Dennis Duby was in the room and present for this initial interview. She asked them about their relationship and Dennis advised that he lived in Pittsford and that he stops by to see Sandy after work and has little contact with DS. She advised that Sandy advised she was the one always with DS. Dennis Duby now excused himself from this and said he had

nothing to do with this and had only driven them to the hospital. She advised she now decided to end the interview with Sandy and contact CFAC again.

73. She advised that when she left the room she spoke with [Doctor 2] and they agreed that she needed to contact a detective and should be looking at this as child abuse, because there was no explanation for the injuries. At this point it was unclear if both legs were broken or just the one.

74. She advised she left and went to CFAC, and met with [Detective] and he was assigned to the case and they returned together to the hospital. She advised that [Detective] recorded the next interview with Sandra Eastman. She advised that Sandra told them she was the primary care giver and that Dennis Duby had never been alone with her daughter. She advised that Sandy then provided several different explanations for the possible injuries to the legs to include that DS had fallen off the couch, that Sandra had dropped her in the pack and play and that DS had been really close to the top of the stairs and she pulled her back by her leg and arm and she hit into the wall. She advised that she followed up on the last scenario about possible rug burns, which were not evident on this child and this was not consistent with being pulled across the carpet. She advised that after each new version she and [Detective] would step out of the room and consult via phone with [Doctor] about the explanation. She advised that [Doctor] had the medical information already and none of the explanations given by Sandra were plausible for the extent of the fractures being seen on DS.

75. She advised that Sandra admitted to knowing that DS was in pain for the few days prior to this and that she had been giving her Tylenol for the pain and DS also stopped crawling and was whimpering as well. She was asked why she didn't bring her to the hospital before, and Sandra said she didn't have a ride. They followed this up with why didn't she call for an ambulance and she advised that Sandra told them she thought she would be in trouble.

76. She advised that they were also being told by [Doctor] that it appeared the two fractures were from distinctly different mechanisms and at different times.

77. She advised that at this point she had a clear picture that this was abuse, that Sandra had told them she was the only one who cared for the child and that she had not gotten her medical help for fear of being in trouble. She advised that at this point they decided they would be asking for custody of the child. An emergency CHINS was filed by [Detective]. She advised that they then had an

emergency hearing and she tried one more time to talk with Sandra Eastman but was denied this by her lawyer. She advised that [Detective] finished up his case at this point and she went on to interview a few more people. She advised that [Family Member 1] had come in to meet with her and express concerns about DS at the home. She advised that she had come in with [Family Member 2].

78. She advised now that a secretary had made a copy of the full file for her and that she had reviewed it a short time ago. She advised that there should be a note on this interview with [Family Member 1].

79. She advised that [Family Member 1] told her of a bruise on the face of DS that she had seen when bringing the older child over for a visit. She advised that [Family Member 1] had asked Sandra about this injury and was told that Dennis had dropped DS into the pack and play and this caused the bruise. [DCF1] advised that she never saw any bruises. She advised that she couldn't remember a description of the bruising.

80. She advised that if they had seen a mark on the face of DS they would have called in a new intake. She also confirmed her meeting with [Family Member 1] was after the beginning of this investigation and not prior to the case.

81. She advised that she then called Dennis Duby on the phone and asked him about this and did in fact say he was at the house and that he was helping after a bath and that he held her and was going to lay her down and she wiggled out of her arms and she fell onto blankets in the pack and play. She advised that she was already aware from [Doctor] that this was not the mechanism for the broken legs.

82. I then asked her if she ever viewed the pack and play and she advised that she did not and neither did [Detective]. I also asked if they had ever discussed this investigative step. She advised that she did not recall this. She then advised that she attempted more follow up at the court hearing and her lawyer told her to stop cooperating with me.

83. She then advised that she spoke with [Relative 3] and asked her about this case and that she had not seen DS since January and was never out of her car seat at her home.

84. I then asked about any follow up and she advised that [Detective] tried to re-interview Sandra and ended up citing her.

85. I then asked her about how quick she transitioned this to a Case Worker. She advised that it was pretty quick as DS was taken into custody immediately and then into court. She advised that after her investigation her role is done.

86. I then asked about whether she was aware that Sandra had made comments about lying to her and the Police. She first advised that she was not aware of these comments and then advised that she did recall this and that it was when she went to the foster home, she recalled them saying something to that effect and that Sandra had told them she lied about how it happened, and that it may have been demons who threw the child down the stairs. I asked what she thought about this. She advised that this had her concerned for her mental health and needs an evaluation. She advised that she told [DCF3] about this information.

87. I asked if she would qualify this as dangerous information. She advised that she didn't get told this directly but she was concerned for her mental health and thought the information needed to be passed on, and her mental health needed to be checked.

88. I then asked about the investigative summary and the risk classification of "Very High Risk". She advised that she would have discussed that report and the case status. She advised that she would have talked to [Former DCF] about this. She advised that she may have discussed it informally with [DCF2]. She advised once her report was done it would have ended her involvement with this case. She reviewed her report and advised that [DCF2] signed this because [Former DCF] was out. She was aware that he had discussed this report with her already. I then asked about the risk assessment. She advised this is based on the risk assessment form and questionnaire and would be very concerned for future involvement with DCF.

89. I then asked if they had looked into the past of Sandra Eastman during this investigation. She advised that she was aware of a past investigation involving her older child. She advised that she was not aware of the DCF report and case involving DS being born Opiate positive. She advised that Sandra may have made her aware of this and that it was from Burlington.

90. I then asked if she and [DCF3] ever discussed the case after and she advised that they did not and that she was not made aware of the case movement or placements after the initial placement with the [Foster Parents].

91. She advised that she had final conversations with both [Doctor 2 and Doctor] and confirmed that they both concluded this was from child abuse. She advised that any medical reports would have passed over to [DCF3].

92. I then asked about Dennis Duby and asked if there could have been anything done differently. She advised no and that she did talk to him at the hospital and he advised he was not involved or around.

93. She advised that when DS was brought in this February with the head injury she was still under the impression that DS was still in DCF custody and had to research this and found that she had been returned home. She advised there was confusion about this due to it not being in the computer at the time of the new incident.

94. She advised that she now had to do a new affidavit for both DS and the infant child to take them into immediate custody.

95. She advised that once her case was closed she had no further involvement with the case. I then asked if she had ever been made aware of the Substantiation Appeal. She advised that she was made aware of this only recently and spoke with [Hearing Officer] about this.

96. I then asked about the appeal block on the initial case determination report. She advised that this was a computer issue and they had to put pending under this for the first 14 days. She advised the appeal was supposed to be within those first 14 days only but is aware of exceptions to this.

97. I asked if she was shocked that DS was back in Sandra's custody and she advised that it did shock her. I then asked if she was surprised to learn this was 3 months earlier and she advised this surprised her and only learned this recently. She did confirm this was a significant risk case and that Sandra had past issues.

98. I then asked if she had ever been made aware that [Family Member 2] had not been allowing visitation of Sandra with her oldest daughter. She advised that she was aware of this past issue and his concerns. I asked if she was aware of the visits being stopped because of Dennis Duby being at the home, and she advised she was not aware of this.

99. I then asked her about her interaction with the State's Attorney with this case. She advised it would have only been around the first court appearances. She was

aware they would be focusing on the issues of the medical neglect. She advised that the States Attorney would not have been given her disposition report but it could have been looked up and shared if requested and could have been accessed by [DCF3].

100. This ended the interview with [DCF1]. (See the digital interview for more details)

101. On 22 April 2014 at approximately 0845 hrs, I conducted a sworn taped interview of [DCF3]. This was done at the law office of [Attorney for DCF 3 and 1] and in her presence. We first covered that this was voluntary and was a criminal investigation. I also explained that I was looking into the case from the time of first report of injury up to her death, and this was not dealing with the death investigation. For complete details of this interview please see the accompanying digital recorded interview. Subsequent to this I provided [Attorney for DCF 3 and 1] with a copy of this digital recorded interview.

102. The following narrative is a summary of the interview of [DCF3].

103. She first advised that she became involved in February of 2013 after the investigation portion of the case was done it got brought to her and this occurred around Valentine's day. She advised the standard process is the investigation is done, and if the child is taken into custody the investigator and the case worker go to the emergency hearing with the State's Attorney. The case worker helps decide what the petition will be. The case then gets transferred to the worker and proceeds to the merit hearing. The investigator completes the report and they are done.

104. She advised that she had access to the case determination report of [DCF1]. She advised that services for Sandra Eastman and the child were coordinated by her. This was the first case of hers with broken bones. She advised that Sandra was even brought in on the planning of the case plan. It was explained to her why each service was being sought, to include parenting and mental health counseling.

105. I then asked about the foster care placement in Chester. She advised that the child was first in Pittsford. When asked about the distance and who is responsible she advised that normally they want the parent to take responsibility but it usually falls on DCF to organize this.

106. We then talked about the injuries and that Sandra was only charged with medical neglect, and not for causing the injuries to DS. She confirmed that she was aware of this and had seen the medical reports of [Doctor] showing two different mechanisms of injury for the legs. I asked if Sandra admitted to this and she advised that she did not. She also advised that it was her understanding that Dennis Duby was involved in Sandra's life at the time of these injuries. She did recall a conversation where she was informed that Dennis Duby had broken up with her, and out of the picture. She advised that this was not confirmed with Sandra and that she did see Sandra being brought to Rutland by Dennis Duby and Sandra confirmed that they were back together and Dennis was involved in her life.

107. We then discussed policy 125, and how they can TPR(Termination of Parental Rights) or go toward re-unification. I asked about how this decision is made. She advised it is not made until they get into the case, but all their training and information is to always work toward re-unification. She advised that this has been a shift away from TPRs.

108. I then asked about the case plans and if they should involve the person in the household. She advised that the adult in the household was Sandy. I then asked if she was ever aware of Dennis Duby living there or staying there and she advised she was not. I then asked about the pending marriage and pregnancy. She advised that he never lived in the home, even after they got married. She advised that the arrangement was for him to live in Pittsford with his girlfriend and would visit Sandy.

109. We then talked about the 6 month review process. I then asked about how this worked with the change to the foster home. She advised there was talk about looking for someone in this area, to make the visits easier for both the child and Sandra. They had looked into this but it fell through. She then advised that the decision to place in Sandra's home was a progression of the visits and parenting that had been supervised at first and then less supervised. She did advise that the drive time with he and Sandra was considered parenting time as she should have been discussing the visit and what was done or would be done.

110. I then asked if anyone ever brought up the fact that no one ever identified who broke the child's legs. She advised no and I then asked if this was a concern of hers and she advised she did not know how to answer that question. She advised that she was aware that Sandra was convicted of the issue of medical neglect but not the physical injury. She did advise that her work would be

supervised. I asked if she and Sandra ever had conversations about this and she advised that she never recalled any actual conversation over this issue.

111. I then asked if the progression to the home was normal and she advised that it was. She advised that the 6 month block was a guideline only and it could be 12 months or even 18 months. She advised that after the 12 months they could extend or move to TPR. I asked what info they based this decision on. She advised that they were being told the visits were going well and that Sandra was meeting the child's needs, attending her counseling and putting the child's needs first. She advised they then had visits in the DCF office and then community release with her and these were day long visits extending the time of each visit.

112. I then asked about if she ever reviewed the notes of [DCF1] in regards to the comment by Sandra about lying to the police and that she had to say something and then about demons throwing the child down the stairs. She advised that she did see these notes and I asked what this meant to her. She had a conversation with Sandy and the service providers about this. She then advised that [Foster Mother] was the one who made that statement and often times family members don't often report accurate information. She advised it was up to her to figure out if it was accurate. She advised that she spoke with Sandra about this and she denied it was a conversation she had. She also asked [Eckerd Worker] to ask about it as well. She advised he reported no information on this.

113. She advised that she never interviewed [Family Member 1 and Family Member 2] and she advised she did not know who may have interviewed them. She did have conversation with them about setting up visits between the two sisters. She advised they never followed through with that. I then asked if they made her aware that they had stopped allowing Sandra to have visits with her older daughter because Dennis Duby was in the home. She advised they never made her aware of this.

114. I then asked about after the marriage, what were the arrangements and what did she think of this arrangement. I asked if she had found this credible. She advised that she had been in the house and saw no evidence that Dennis was living there. She was aware that he visited there. I then asked if he was ever considered for being put into the case plan. She advised there was talk of that and she checked DCF records and found none on him, no known issues with his current children, no indication of drug use and that he was already parenting his 2 children.

115. I then asked if she ever reviewed Sandra within her system, given the fact that she just related they had reviewed Dennis Duby in their system. She advised that she only took what was given to her in the file. She advised she never looked to see if there was prior involvement with DCF on Sandra. She again denied ever being made aware that Dennis Duby was living there.

116. We then talked about information by [Foster Mother and Foster Father]. She advised that there were some conversations and these were about [Relative 3] drinking, which was not corroborated. She advised the [Foster Parents] did not support the re-unification plan and she did discuss with them about a possible adoption at the end.

117. I then asked about what a very high risk category meant to her and she advised that significant damage was done to the child.

118. I asked if anyone above her ever questioned the re-unification plan ever get questioned and she advised that it did not. She advised that there was little involvement with the child's attorney and the State's Attorney, and that [State's Attorney's Office] had been provided the copies of the case plans. She advised that Dennis Duby was never involved in those case plans. She advised they never had any reason to do this. I then asked about the allegation of facial bruising and she advised that she had never been made aware of this. I then asked if she had looked closely at [DCF1]'s notes about this and she advised that she had not. She was also not aware of the interview of Dennis Duby where he related he may have been responsible for the facial bruising. She then advised that she saw the child after she was brought into custody and never saw any bruising. I then explained the allegation was for bruising about 2 weeks before the broken legs.

119. I then asked what else we should know about. She advised that they watched Sandra's interaction and saw no issues. She advised that she was making her mental health meetings and sessions as well. I then asked about a note for a mental health evaluation. She advised that she did not recall that, but did talk about getting one, and didn't follow through with that. She advised that they talked with the providers and she was already in treatment and this wouldn't give us anything more.

120. I then asked about the involvement with all the lawyers (SA and attorney for DS) and if they ever questioned the re-unification plan. She advised that it was never questioned and that everyone signed the plan.

121. I then asked about the plan to put her in a home closer to the mother. They advised that they thought moving her to a stranger's home may not help the child to transition home. She advised they would expect some regression if they did this so they placed her in the home of Sandra Eastman.

122. This ended my interview of [DCF3].

123. On 24 April 2014 at approximately 1018 hrs I conducted a sworn taped interview of [DCF2]. Present with [DCF2] was her attorney [Attorney for DCF2]. This interview occurred within a small conference room at the Vermont State Police Office of Professional Development in Pittsford Vermont. At the onset of the interview we clarified that I have not and would not be listening to her prior interview given to DCF staff in regards to this case, and that this was in fact a criminal inquiry at this time. For complete details of this interview please see the accompanying digital recorded interview.

124. During the interview she advised that she is [identifying information removed] with about 100 open cases. She advised that she became involved after [DCF1] finished her investigation she would pass it up to a worker and this was assigned to [DCF3] and she would have been made aware of the case then. She recalled that the case involved the child being brought into the hospital with broken legs.

125. She advised that it is [DCF3]'s job to set up the case plan and work with all the other service providers in the case. She advised these other providers included probation and parole and Eckerd Family services for family time coaching. She advised that Sandra was also seeing a mental health counselor as well.

126. I asked if she is involved in developing the case plan and she advised that the plan would be brought to her, she would review it, make any changes and then sign off on it. I asked about the re-unification plan and if some cases would not track this way. She advised that it would be very rare and that there are few TPR (Termination of Parental Rights) recommendations from the start. She then related a recent case where this did occur and advised the child was a medically fragile baby and the family had a history of involvement with DCF. I then asked if Sandra Eastman's DCF involvement was ever reviewed in this case. She advised that she was not certain of this but did know that she had a sex offense case. I then asked if she was aware of the drug issue at birth of the child. She advised that she could not recall this.

127. I then inquired about policy 125 and the right to TPR in high risk or instances of severe physical abuse. She advised that option is not used often and that all the training pushes toward re-unification. She advised that all the push is toward this and that they are taught children grow up best in their own families.

128. I then asked about the case determination report and she advised that she does not sign off on these and then corrected that she did in this case because [Former DCF] was out and had spoken to her about it. He had reviewed it and it needed to be signed and asked her to review it and sign it. She advised that she did sign off on it but did not supervise the investigation by [DCF1]. She did advise that she reviewed it. I then asked about the notes of [DCF1]. She advised that she read it but did not remember the allegations of facial bruising and the interviews of Dennis Duby. She advised that she did not recall that at the time but has since seen more of the files and does have more information about the case now.

129. I then asked about the risk level being Very High and she advised that was why she was brought into custody. She advised that they have some cases open where the risk is Very high and the kids remain in the home.

130. I then asked about case plans and who they would involve. She advised that depends and in this case it was on mom. She advised that if there is a boyfriend involved with issues it would include them as well. I then asked if that would include someone helping with care taking functions like bathing and laying the child down to sleep. (Dennis Duby had provided an interview with [DCF1] where he detailed dropping her in the pack and play after a bath and this was what would have caused the facial bruising. This incident was prior to the child being brought in with broken legs) She advised that this would be yes but thought Duby was not living in the home. She advised that if she knew this it may have changed plans. She then advised that certainly if the boyfriend has a history of drugs or violence. I then asked how about if we never identified who broke this child's legs. She advised that she did not believe he was a suspect at all. I then asked in hindsight what was missed. She advised that she wished she knew sooner that he was in the home. She advised that she recalled hearing there was a boyfriend and that [DCF3] had checked him out. He had no record and no history with DCF. She advised that she would have told her to look him up.

131. I then asked again, knowing what she knew now, did Dennis Duby get overlooked. She advised that maybe he should have been looked at more but Sandra got substantiated. She advised that given all that she knows now, he should have been looked at.

132. I then asked about the appeal hearing and she advised that she never knew of that when it had occurred.

133. We then discussed how the substantiation was for the legs but only convicted of medical neglect.

134. We then began to talk about case progression and placement. We then discussed the 6 month process, and that the case plan progression is in 6 months increments, with administrative reviews and a permanency at the 12 months window. She advised that the child can be transitioned home to the mother's residence. She advised of the fact that the visits were a part of the process. I then asked about another home in the Rutland area and attempts to change this placement. She advised that there was a relative interested and they were working on that and it fell through and they then placed her in the mother's residence. The idea of moving her to Rutland would have been to make contacts easier. She advised they had positive reports from the family time coach. I then asked about [Eckerd Worker] and she advised that he was no longer with Eckerd.

135. She advised that in February after the death, she was able to review the whole file. I then asked if in this review she found things I should know about. She advised that the case plan went to court without her signature. We then began to discuss the case plans and how these get presented and interaction with the State's Attorney. She advised that it would be the workers responsibility to interact with the SA. She would be responsible to make him aware of all issues. He doesn't get a copy of the case notes unless he asks. She then advised that there were multiple persons involved in the court process.

136. I then asked about the checks and balances of information sharing. She advised that not really and any of the attorneys involved can come to her office and read the files and make copies if they wished to do so. I asked about the SA, she advised that it was only if he asks for them, indicating the information sharing was not automatic in this process. I then asked if anyone came in on this case and she advised not that she was aware of but no tracking of this. She advised that

they would have had the affidavit. She advised the case plans do get mailed out to the parties involved. (This does not have the case investigative information)

137. [Attorney for DCF2] brought up that in her experience all the information is very segregated and only in substantiation issues does the information get shared.

138. I then asked if she had any recommendations and what they would be. I prefaced this by saying that I understand that I have all the information in this case, but what I see shows a much different picture than what is portrayed in just case plan. She advised that she never knew about the appeal report and this should have gone directly to the workers and made part of the file. She advised that what she knew from that, would have changed because Sandy was not accepting responsibility and blamed Dennis Duby for the broken legs. She advised this would have probably put him on the case plan. She then advised that [DCF1] ruled him out.

139. We then discussed that she did not have all the information. She thought Dennis had been ruled out, but was unsure how extensive this investigation was. She then advised that once the case comes to her group they are no longer continuing the investigation, just pushing the case plan and moving forward.

140. We again discussed the bruising issue again. She advised that they never saw the bruising and was not sure what was true or not. We then talked about the family trying to call in on several issues. I then asked about the issues with the other child and if she was aware that Sandra was not being allowed access to her other daughter for almost a month a half prior to the broken legs.

141. She advised that she had not reviewed the medical reports in this case, and would not typically do so. She advised that she would not always read all the details. This would have been used by [DCF1].

142. I then asked about the case and if there were any other unusual things in this case. She advised that there was not and that [DCF3] was dealing with all the services and things were going well. She brought up that people say 8 months was soon but they have a 12 month permanency. She advised this used to be 18 months, and did advise there are exceptions and could change the time frames.

143. I then asked about the request and suggestion for a mental health evaluation. She advised that she found it since and asked [DCF3] about that and

that was not picked up on during the time of the case. She advised that she was sure an initial assessment may have been done but the evaluation did not occur.

144. I then asked that knowing that she reviewed this, what she saw as gaps in the system. She advised the documentation could have been better in this case. We again talked about information sharing and she advised that the information is not shared without request. We again talked about how the appeal report never made it down to her or the case worker. She then discussed that she was not sure how she was even able to appeal this so late.

145. This ended my interview of [DCF2]. (See digital interview for more details)

146. On 30 April 2014 I met with [State's Attorney's Office] at his office. I subsequently conducted an interview with him regarding the interaction with this case in both criminal and family court. I explained that I was investigating the case and all involved to review if there was any Criminal Neglect of Duty and he acknowledged he understood this. I asked him about how the case progressed, and he advised that there were concurrent criminal and CHINS cases going on at the same time, until the criminal case was resolved. He advised these progressed together at first. I then asked what he based his case progression and information on. He advised that he relies on the team of investigators, in this case, [DCF1 and Detective] to get the information about what may have occurred and how. He then advised that he relied on the CHINS petition affidavit filed by [Detective] in this case. He acknowledged that this affidavit described the injuries but not who or even how they occurred. I asked about what medical reports or information he had received and did he have access to the report of [Doctor] 3-page report. He advised that the initial documentation showed some conflict about the exact fractures and timing of these. I then asked about how he would proceed in a case such as this, where it became uncontested. He advised that he would rely almost entirely on the case plan of the DCF Case Worker, in this case, [DCF3]. He advised that the initial hearing was held on 2-19-13 and that another lawyer handled this first appearance. He then advised they had a status conference on 2-28 and the issues that were un-resolved was over who actually broke the legs of victim. He then advised that they would be unable to move forward until the 3-21 hearing where Sandra Eastman stipulated to the merits of the case by admitting to neglect and failure to get immediate medical attention. He acknowledged that this still did not answer who had broken the legs but it resolved the issue for the court to allow case progression. He then advised that the criminal case resolved on 7-3-

13 with a change of plea by Sandra Eastman. She only pled to the medical neglect and took no responsibility for who broke the legs, as that was not charged.

147. I then asked about who was responsible for the case plan development and how that would have occurred. He advised that this was on DCF and they would develop the plan to address any issues identified and the family members involved. I then asked if he had ever been made aware of Dennis Duby living in or staying at the home and he advised that he clearly had not been made aware of that at the time, but was aware of it now that he was made aware of more info after the death of the child. I then asked him if he had ever seen or been given the case determination report of [DCF1] and he advised that he never got that report. He went on to advise that DCF would have used this and the criminal investigation affidavit to find the family issues that need to be identified and addressed.

148. I then asked about the placement back into the home of Sandra Eastman. He advised that he had never been informed of that placement and that he normally would not as this was the responsibility of DCF to place the child. He advised that he rarely knows the placement changes until after the fact and is not even sure if there is a mechanism to challenge it if he had known about it.

149. I then asked about whether he was ever made aware of the appeal of substantiation by Sandra Eastman and the findings of that hearing by [Hearing Officer]. He advised that he had never been made aware of those findings at the time but had seen them since and advised this would have represented a very big change from the disposition report, especially where she was now denying any involvement and actually indicating that Dennis Duby must have been responsible for breaking the legs. I asked how it was that he never got this report, nor was the court ever made aware of it and he advised that he only knows that the report was forwarded to [DCF4]. I then asked if that report would have changed his process. He advised that if he had seen that report he would have certainly had a different position on the return of custody, especially given the conflicting issues of who may be responsible, and that if Duby was in fact responsible he was never in any case or family plan. I then followed this up by asking if he had ever been made aware of Duby being in the picture and life of Sandra Eastman, including the marriage. He advised he had not been made aware of Duby being in the picture and that he never showed up in any case plan by DCF.

150. I then asked if he ever recalled any allegation of facial bruising that may have occurred a week to 10 days prior to the victim being brought in for the broken legs. He advised that he had no recollection of that. I then explained the allegation as outlined in the intake report and described the phone interview done by [DCF1], where Dennis Duby advised that he had dropped the child while putting her in the pack and play after a bath. He advised that he had never been made aware of that information either.

151. I then asked him if he could tell me where he perceived the gaps were in this case. He advised that he was surprised that [Detective] missed that Duby was in the home or even possibly involved. I then explained that it is unclear if [Detective] even knew about Duby as he had left the hospital before he arrived. He then advised that he should have looked to try and determine who had broken the child's legs. He then advised the lack of information sharing between all parties did not make sense and it appeared a lot of information never got to his level or was even shared amongst others involved.

152. I then asked him why there was no move toward a TPR (Termination of Parental Rights) given that the injuries were serious and no one had ever been identified as being responsible for the fractured legs. He advised that the statutory change in 2010 clearly made it harder and that the primary goal was toward re-unification as in the best interest of the child. He advised that single change puts the parent first very often and reinforces that re-unification is the first option and should be the focus.

153. I then asked, that given all the information he is aware of now, what would he have changed, or what would have changed this case progression. He advised that the biggest thing was not seeing the report of the substantiation appeal and that it had been sent to [DCF4] and he still signed off on the final case plan. He advised the next thing was that Dennis Duby was not taken into account and that he was never in the case plans.

154. [State's Attorney's Office] then advised that case orientation should be for the safety of the child first. I asked if that happens and he advised that because of the work toward re-unification the parent's interests are often put ahead of the child's.

155. I then asked if he had ever been made aware of any prior issues with Sandra Eastman and DCF and he advised that he was never made aware of the issues (the child being born opiate positive) and if those were on record they

should have been addressed in the case plans by DCF. [State's Attorney's Office] went on to advise that it appeared that the DCF disposition report was the essential hub and all the information of the case should have been in there to be accounted for and it was not. He advised that the disposition report is the starting blue print for the case progression and really needs to be checked for all the information available. He then advised that he was still puzzled that if [DCF4] had that substantiation appeal report, then how could he have still signed off on the final hearing report of 1-16-14.

156. I then asked if he wished to go back over this information in a taped interview and he advised that he did not wish to do that. This ended my interview with [State's Attorney's Office].

157. On 12 May 2014 I met with [DCF4] at the Vermont State Police barracks in Rutland Vermont. At that time I explained to him that this was a criminal investigation and review of the entire case involving DS and that this was not part of any internal or Human resources review. He acknowledged that he understood this. I had also advised that this was voluntary and I appreciated him coming in for this interview. I explained that I only had a few questions for him and asked if he minded if I taped our interview. The interview was digitally recorded and began at approximately 0901 hrs.

158. I first asked him if he could tell me how he is employed and what that entails. He advised that he directly supervises about 5 people, and oversees the office. He also advised that in most cases that go along in a normal progression, he is not made aware of many of the case details. He advised that it would be for unique or unusual circumstances that he would step in or arrange for consultation or help with a particular case.

159. I then asked him if he remembered the case involving DS, which came in on 14 Feb 2013. He advised that he had a slight recollection of the case and that he had not done any independent review of the case or case files since the death of DS, as he knew this would be done by the main office.

160. He advised that he has been with DCF for about 4 years and was familiar with the case work process. I then asked him about the substantiation appeal process. I then explained that an appeal had been filed and reviewed with comments indicating Dennis Duby may have been responsible for breaking the legs of DS. I asked him if he recalled this or was aware of this and he advised that he was not. I then showed him the Substantiation Appeal report that was sent to

him and Commissioner Yacavone. He again advised that he did not recall seeing this report. I then explained the report and some of its content and showed him the CC page and he was asked how he could not have seen this report. He advised that it would have gone through an administrative person.

161. I then asked about the case plans and if he signed off on the final plans. He advised that the supervisor would have signed it and may have noted it on his behalf. I then showed him the final case plan and he advised that he did not sign off on this one and would sign off on them if there had been a disagreement about the final plan, in case there was an appeal.

162. I then asked if he had discussions with his staff since the death and he advised only to be supportive and not to discuss the past case.

163. I then asked if a care taker living in the house should have been put in the case plan. He advised that it would depend on the circumstances. He advised that if they were a care giver they may be included.

164. I then asked if there was any explanation for why this substantiation appeal report did not make it to the case workers so they could have the information to consider. He advised that he did not have an explanation for that. I then asked if he agreed that the information contained within that report may have changed the final case plan or placement back within the home, especially as this now identified who may have broken the legs. He advised that he was unsure and was not familiar with all the circumstances of the case. He advised that he did not want to speculate.

165. I then explained that this new information in the substantiation appeal report was the first to identify who may have broken the child's legs. I asked him if he agreed this is information that should have been put out and considered, especially given that the child was being placed in a home where Dennis Duby would be. He answered "Theoretically".

166. I asked if there was a process that could change to prevent this gap in information from happening in the future. He advised that as a matter of speculation that they could possibly ensure that any appeal results be considered in the case plan review process. He advised that there currently is no check list of material to be considered, and that this may be a good thing to have in the future.

167. I then asked if there was anything he would like to add and he advised that they were working to create case consultation settings and could solicit more input. He further added that [DCF2 and DCF3] were very experienced and dedicated. He advised that this case never came to his attention.

168. This ended the interview of [DCF4] (For more details see the digital interview of [DCF4]).

Case Findings: (The following section of this reports details item of interest found in the case file review and any explanations found or lack of any explanation.)

169. Item #1. During the case file Review it was noted that the initial case was reported on 14 February 2013, from officials at the Rutland Regional Medical Center. Indications were that Sandra Eastman had come in with DS and Dennis Duby. I noted that Duby was never interviewed by Law Enforcement or any time line of his possible involvement checked.

170. In instances of child abuse with severe trauma or injuries, it is important to establish who may have had access to the victim and what they may have seen or heard in regards to the possible injuries. Interviewing individuals independently is a best practice to establish any possible inconsistencies in the version of events being reported.

171. In an interview with [DCF1], she indicated that she responded to the hospital alone at first and met with Sandra and Dennis Duby together in the emergency room. During the brief interview within that room, Duby and Eastman were together and Sandra Eastman was claiming that she was the only person who took care of DS and Duby claimed he was not involved and only gave her a ride to the hospital. He then excused himself and left the hospital and was no longer present when [Detective] arrived.

172. There is no indication in the Rutland Police report that Duby was ever identified as possibly being present. There is also no indication Duby was ever interviewed by law enforcement.

173. Item# 2. The original affidavit filed for the CHINS petition only identified the child as being in immediate danger from her surroundings. This section noted the basis was the injuries and the fact that Sandra Eastman had provided inconsistent information on how these injuries could have been

sustained. The investigation to this point, 14 Feb 2013, had been unable to identify who may have actually caused the fractures to DS and even how they may have occurred.

174. Subsequent to this, Sandra Eastman was only charged with Cruelty to a Child under the age of 10, for failing to provide medical aid in a timely manner. This did not in any way reflect culpability for causing the injuries and still left the identity of who did this unanswered.

175. This lack of identifying the actual person or persons who may have actually caused these injuries was a common theme throughout the entire case progression from the time DS was taken into custody all the way up to the point to return to the home and to the final disposition hearing held on 2-7-14. Several concerns with this failure to identify the accused raise the following questions:

- If the identity of the accused is not known is that person still in the life of DS and having access to her after return to the home, during re-unification.
- If Sandra was not involved, is she protecting the identity of the accused and therefore exposing DS to future danger.
- No timeline was done to establish exactly who may have had access to the child in the time frame of the injuries as described by [Doctor] as being 7 to 10 days prior to being brought to the hospital.

176. Both the CHINS and the charging affidavit indicate that Sandra was saying she had been the only one alone with DS.

177. [DCF1] interviewed Sandra at RRMC. Sandra stated that she did not know what happened to juvenile A and that she started noticing Juvenile A was in pain on February 13, 2012, when Juvenile A stopped crawling and seemed to be in pain. Sandra stated that she did not seek medical treatment sooner because she did not have a ride. When asked by [DCF1] shy she did not call an ambulance, Sandra stated she thought the pain was coming from Juvenile A's club foot. Sandra stated the no one has been alone with Juvenile A except for herself." (From affidavits dated 2-14-13 and 3-13-13 by [Detective])

178. Despite this assertion by Sandra that she was the only one alone with DS, several contradictions to this were revealed in the investigation very early on. Both [DCF1 and DCF3] were aware the Dennis Duby was in the life of Sandra Eastman. [DCF1] conducted an interview of Duby by phone on 21 Feb 2013,

during which time he disclosed to being present with and helping take care of DS after a bath. This phone call was made to Duby because of an allegation of facial bruising in the case intake:

179. Excerpt from intake report 143021 – [Family Member 1] advised that [Family Member 1] spoke with someone at RDO, to advise that when [Family Member 1] dropped **** off to visit with [Family Member 1], there was bruising on DS face (both left and right sides) At that time Sandy told [Family Member 1] that Sandy's boyfriend Dennis had dropped DS into the pack and play."

180. Excerpt taken from the Case Determination Report of [DCF1] – "On 2/21/13 this investigator spoke with Dennis Duby, Sandra' boyfriend at the time. Dennis stated that about a month before he was putting DS into her pack and play and she was just out of the bath. Dennis stated that as he layed her down she dropped about a foot out of his hands and landed on her stomach in a laying position onto a blanket. Dennis stated that DS did not cry or seem bothered by it at all. Dennis stated that DS did not hit her legs or get them caught on anything."

181. This interview would indicate that Sandra was not the only person ever alone with the child and has Dennis Duby admitting to helping with care taking functions of the child. The other aspect of this is that the story of Duby would not have been consistent with bruising a face or causing the leg injuries.

182. It is uncertain if this information was ever shared between [DCF1 and Detective].

183. Item #3 : The possible mechanism or manner in which these injuries occurred was never fully discovered or followed up on.

184. [Doctor] was clear at the onset of this investigation that these fractures were from 2 different mechanisms and would have been caused by significant force. On 14 Feb 2013 Sandra Eastman was interviewed and gave several different versions of how this happened, all of which were found to be inconsistent with the injuries and the dates which they may have occurred.

185. I noted no visit, either consensually or via a search warrant to the home of Sandra Eastman to look at the conditions, or view the pack and play to see if there were any issues with the crib or the home. Viewing the residence can often reveal further discrepancies in stories provided or even may reveal issues which could explain some injuries.

186. [DCF1] became aware by 25 Feb 2013 that Sandra Eastman was telling others that she made the stories up to the Police and DCF.

187. Excerpt from Case Determination Report of [DCF1] - "On 2/25/13 this investigator met with [Foster Mother and Foster Father], paternal aunt and current placement for [DS]. [Foster Mother] stated that Sandra told her that she told DCF and the Police the story about pulling [DS] away from the stairs because she felt like she needed to come up with a story. [Foster Mother] stated that Sandra stated to her that demons had thrown [DS] down the stairs."

188. I subsequently confirmed this conversation during interviews with [Foster Mother and Foster Father] as well as with [DCF1].

189. Item# 4: I noted that there had been minimal follow up on Dennis Duby throughout this case, despite investigators and the case worker knowing about his involvement. It was also learned that his involvement was not made known to either the States Attorney involved in the case or to the Attorney for the child.

190. The only interview of Dennis Duby was a phone interview by [DCF1] on 2/21/13. He was never interviewed by Law Enforcement and he was never asked to be part of any of the case plans or part of the plan for re-unification.

191. In interviews with [DCF3], she advised that she was aware of his involvement but not that he was staying at or living at the home. This was followed up by questions about the marriage of Duby and Eastman and the fact that she was pregnant with Dennis and her child. [DCF3] acknowledged being aware of this and that at one point she did research the DCF records on Dennis Duby and found nothing.

192. [State's Attorney's Office] advised he had not been made aware of Dennis Duby being in the picture. He advised that he had only become aware of this after the death of DS. [State's Attorney's Office] was asked about, and advised that he never received the case determination report of [DCF1].

193. Item# 5 I noted a very obvious lack of information sharing throughout the entire course of this case progression. It appears that I was the only person that had the ability to have access to all the materials developed in the course of this case and investigation. This was noted to be between all agencies and at all stages of this case. Several examples of this area as follows;

- There is no indication that the interviews conducted by [DCF1] were ever made known to [Detective] for follow up.
- The case determination report and additional documentation was never made known to or provided to [State's Attorney's Office].
- [State's Attorney's Office] advised that he relied heavily on the charging and CHINS affidavit and the case plan developed by [DCF3]. He advised that if he wanted additional information he has to request it, and it is not just provided in each case. This was also confirmed by [DCF2 and DCF3].
- [State's Attorney's Office] had never been made aware of the allegation of facial bruising and the possible involvement of Dennis Duby in this incident, in the weeks that preceded the broken legs incident.
- DCF never even used their own files on Sandra Eastman when developing their case plans or assessments. [DCF3] advised that she did research Dennis Duby at one point but never looked into past issues with Eastman. She was not aware of past drug allegations, and the fact that DS was born opiate positive.
- [DS's attorney] was never made aware of Dennis Duby being in the picture and never given any information on the other allegations of facial bruising as well. She was also never told what Eastman had pled to, and had always worked under the assumption that she had taken responsibility for the breaking of the legs of DS. She advised that is was only after the death of DS that she learened differently and had since found out about the substantiation appeal hearing as well.
- [DS's attorney and State's Attorney's Office] had never been made aware that DCF had decided to and had placed DS back into the home of Sandra Eastman in early fall of 2013.

194. Item# 6: I received a note with the case file, that indicated the following "Reach Up note reflecting contact with [DCF3]. Notes state that Sandy will be getting a psych eval in three weeks. Indicates that [DCF3] has not gotten Lund notes."

195. During the case progression Sandra Eastman was seeing a mental health counselor, however no psych eval was apparently done. [DCF3] had advised that she did discuss it with the counselors and they saw no additional value to this. I asked if they ever took into account her story about "Demons throwing the child down the stairs". She advised that she had asked Sandra about that and she denied it, so it was not addressed.

196. It would be important to have a valid assessment of the mental health of the primary care giver for a child. In this case I was able to review notes within the DCF files that indicate past drug use and abuse in front of the child, as well as 2 sources of information about Sandra saying demons may have thrown the child down the stairs.

197. It appears this issue may have only been summarily addressed with no full mental health screening. This cannot be fully confirmed as I was not allowed access to these files or to the Reach Up Notes.

198. Item # 7: This case involved an appeal of substantiation by Sandra Eastman, and this substantiation was upheld by reviewer [Hearing Officer]. At this appeal hearing Sandra Eastman testified about the allegations around the broken legs.

199. Excerpts taken from the report of [Hearing Officer] (dated 5 Dec 2013) - "You did not wish to contest the merits of the 2008 substantiation of sexual abuse. You did want to contest the department's substantiation determination of physical abuse of your daughter DZ. Your position is that you do not know what happened to her. You said "I did plead guilty to the medical neglect I did do that. As far as the broken bones, it was my boyfriend that dropped her not me. I gave her Tylenol because of her club foot. She is a very active child and refused to wear her brace. She would not keep it on."

200. "You also admitted to lying to the detective because he made you feel obligated to provide an explanation. You said "so I made it up".

201. The information from this appeal was forwarded to Commissioner David Yacavone and [DCF4] in a report dated 5 Dec 2013. This report is prior to the actual permanency hearing and final return of DS on 7 Feb 2014.

202. [State's Attorney's Office] advised in an interview that he was never made aware of this information and should have been, as it contradicted the premise that Sandra may have been responsible for the broken legs. He advised that if he had seen that report he would have certainly had a different position on the return of custody, especially given the conflicting issues of who may be responsible, and that if Duby was in fact responsible he was never in any case or family plan. I then followed this up by asking if he had ever been made aware of Duby being in the picture and life of Sandra Eastman, including the marriage. He advised he had

not been made aware of Duby being in the picture and that he never showed up in any case plan by DCF.

203. I subsequently interviewed [DCF4] and asked how this information never made it to investigators or was not shared. I then asked if there was any explanation for why this substantiation appeal report did not make it to the case workers so they could have the information to consider. He advised that he did not have an explanation for that. I then asked if he agreed the information within it, may have changed the final case plan or placement back within the home, especially as this now identified who may have broken the legs. He advised that he was unsure and was not familiar with all the circumstances of the case. He advised that he did not want to speculate.

Conclusions:

204. After a full review of the DCF and law enforcement case files provided I have not been able to find any information or evidence that would support the charge of Criminal Neglect of a Public Official.

205. I do note a systemic failure of information sharing and accountability within the case and throughout the case progression from the onset all the way to the final hearing in which custody was given back to Sandra Eastman. (This was all outlined above in the findings section) Given the amount of agencies and personnel involved in each and every CHINS or custody case, the sharing of information is paramount to informed decisions being made on behalf of the child at each step within the process. In this case the gaps in information availability limited the ability of each step further down the case progression to being a truly informed and fact based decision.

206. During the interview with several of the DCF workers and with [State's Attorney's Office] it was stated that there is an overwhelming push from the onset of most cases for re-unification. It was brought up that this focus on reunification very often puts the needs of the parents often above the needs and interest of the child or victim. [State's Attorney's Office] advised this was a dynamic switch due to legislation in 2010 that adopted this as the primary and suggested course of actions. There are also Federal mandates which require a push for permanency within a 12 month period.

207. During the interview with [DCF4] and others, most agreed that the information sharing needed improvement and should somehow be automatic and not have to be requested at each stage of the process. Lawyers for the children are even limited in the information they receive and have to request additional information if they are made aware of it during the process. [DCF4 and State's Attorney's Office] also suggested that a checklist of information could be helpful to prevent the gaps that occurred within this case.

Report of Lt. James Cruise