Case Narrative – 14A102352 Det. Lt. James Cruise

Incident:

This case documents the investigation and review of all files and actions of public officials surrounding the case of juvenile PG up until the time of his death on 4-4-2014. The case review is to see if any actions or inactions rise to the level of Criminal Neglect.

Evidence/Exhibits:

1. Case files received from DCF to include the following:
    - The initial DCF case file with
        - Case notes section - 70 pages
        - Intake information and notes – 46 pages
        - Hearing and case info 76 pages
        - Family and contact info 98 pages
        - Safety planning info 5 pages
        - Health info 26 pages
    - Case timeline 5 pages
    - Intake [Intake 1] 4 pages
    - Medical report associated with intake [Intake 1] 6 pages
    - Court Transcripts 158 pages
    - Intake [Intake 2] 6 pages
    - Case notes for [Intake 1] 10 pages
    - Chapter 49 case track 1 page
    - DCF Policy on Response to Child Abuse and Neglect 20 pages
2. Audio of the intake call for [Intake 1]
3. Digital interview of [Family Member 1]/[Family Member 2]
4. Digital interview of [DCF 1]
5. Digital interview of [DCF 2]
6. Digital interview of [DOC 1]

Persons Interviewed:

[Family Member 1] dob [redacted]

[Family Member 2] dob [redacted]

[redacted]

So Burlington, VT [redacted]

[DCF 1] dob [redacted]

DCF Burlington 863-7370

[DCF 2] dob [redacted]

DCF Burlington 863-7370, [redacted]

[DOC 1] dob [redacted]

Department of Corrections , 50 Cherry St

Burlington VT 863-7432

Narrative:

1. In May of 2014 myself and Lt. Brian [DCF 4] were informed by Capt. Sinclair and Major Hall that we would be conducting the review and investigation into the actions leading up to the death of juvenile PG on 4/4/14. I was also informed the case would be handled at that time by the Chittenden States Attorney's office and we were to meet with them to get the case information.

2. On 22 May 2014 we met with [SA 1] and [SA 2] of the Chittenden County States Attorney's office. The purpose of this meeting was to get the information known on this case and the events leading up to the death of PG. In the ensuing conversation we learned that PG was brought to the hospital on 4-4-14 and pronounced dead and that this was shortly after a visit to the home by DCF worker [DCF 2]. We also learned that in connection with the homicide investigation DCF worker [DCF 1] was interviewed and that this interview was conducted by another DCF worker, [DCF 5], at the request of Officer [Police 1]. [SA 1] had information from this interview in her possession. We discussed this briefly and I advised that we did not want to take any of that information or know of its contents as we were uncertain of the context it may have been obtained and I did not want it later precluded by any potential Garrity Rights issue.

3. We then got further information on the case including that the mother was Nytosha Laforce and the boyfriend was Tyler Chicoine. We were also informed that the mother of

Nytosha was [Family Member 1] and we were given her address and contact information, along with her boyfriend's name of [Family Member 2]. We then went over timeline information and learned the original DCF case and custody was opened in June of 2013 after Nytosha had been arrested in New Hamsphire on a probation violation. PG was subsequently placed with [Family Member 1] and after being transferred back to Vermont, Nytosha was released to participate in a Lund program. We also learned that the DCF case was closed by the court on November 13th, 2013 and custody was given back to Nytosha. They also advised that the court allowed DCF one month to finish contact and information with Nytosha and PG, and DCF ultimately closed their file in January of 2014. We were also told that it was uncertain if the assigned case worker ever did any home visits with Nytosha. We were then informed that a doctor from the hospital made a referral to DCF regarding PG due to a visit to the hospital because PG was throwing up and had stopped walking and also was found to have 2 unexplained bruises along his neck. We were then given the information that after an intake on 2 April 2014 from the Hospital, DCF worker [DCF 2] arranged to visit Nytosha on 4 April 2014. We were told that directly after this visit, 911 was called reporting that PG was not breathing and may be dead.

4. On 22 May 2014 I received notice from Capt. Sinclair that this case was to be reviewed by the Attorney General's office, as we would also look at and review the conduct of any officials from the Chittenden County States Attorney's office.

5. On 27 May 2014 myself and Lt. Miller went to DCF headquarters in Essex to meet with [DCF 3]. The purpose of this meeting was to receive any files DCF had in their possession pertinent to our review and investigation. [DCF 3] provided copies of all their files and advised she had a copy of the actual recording on the intake from the hospital Intern as well. We asked about any Lund program notes and were informed they had none as Nytosha was given back custody prior to these being obtained from Lund. We then asked about the [DCF 5] interview of [DCF 1] and [DCF 3] advised this interview was not considered a personnel interview and was only done at the request of CUSI (Chittenden Unit for Special Investigations) in connection with the homicide investigation. The original court petition was done by [DCF 4] and this was in June of 2013. The custody case was closed by the court in Oct of 2013 after Nytosha had completed all she was asked to do by the courts and DCF. [DCF 3] further advised the DCF case was closed in January 2014 after a final visit. She also advised that case had gone from DCF worker [DCF 6] and then to [DCF 1]. Prior to leaving we listened to the entire intake audio from 4-2-14. We were subsequently provided a copy of this audio as well.

6. In listening to the audio tape for intake [Intake 1] I noted the following information; The call was received on 2 April 2014 at 1947 hrs. The caller was [Doctor 1], a Pediatric resident from the Emergency Room at Fletcher Allen. He advised that PG had been brought into the Emergency Department for acute Gastro Enteritis, and that this was not a major medical problem and looks pretty good. He went on to advise that they had noticed that PG had two small bruises on his neck, one on each side of his neck, and that this was an uncommon place to get bruising. He advised that they had looked at his blood counts to see if there was any underlying issue which would make him prone to bruising and reported the family had not noticed these. He advised that the family seems to be doing everything well, but don't have an explanation for the bruising. He advised they had a history with DCF and mom was in Lund, and was now with step dad and PG's Biological dad is in prison. He advised they just wanted to see if they had an open case. He advised that the spot of the bruising was very unique and symmetrical on each side and although it could be accidental he advised it was just weird and it would not be something he could get himself. He advised that he did tell the parents he would be contacting DCF. He advised that the step dad was somewhat defensive about this but the mother seemed fine and that she had worked with DCF before. He then provided the names of the child, mother and step dad, and that there were no other kids in the home, and was unsure on day care issues. He additionally provided the address of Nytosha Laforce as well. He then provided the biological dad as [Boyfriend 1]. He then described the bruising as circular bruising about 1 to 1.5 cm in diameter on each side of the neck. He subsequently provided that the child did have a daycare center and that it was BlueWater Center Daycare. He advised the baby was otherwise healthy and doing really well. He advised that he was not vaccinated and being treated by a naturopath. He advised that both Laforce and Chicoine were very appropriate with PG and that he had just never seen bruises there. He then advised that child seems plump, well cared for, clean and has no rashes and "looks fantastic". He advised that he just needed to call. He then described that the bruises were on the soft part of the neck just below the corner of the jaw. He advised that he talked it over with the attending Emergency Doctor and he felt the bruises were accidental because if you were choking a little baby he would not be as alert looking as he is now, because you would have to press too hard. He advised the bruising was brown in color and was an older bruise. He was given the intake number assigned to the case and that he could send the medical notes via fax.

7. In reviewing the intake report from that phone call I noted the information with intake [Intake 1] was an accurate summation of the report as contained within the audio tape. At no time during the audio tape of the intake call or on the intake itself is there any mention of the child no longer walking. The third page of the intake has a section noted "Report Acceptance/ Response Priority". This section notes the report was accepted by [DCF 7] on 4/2/2014 at 10:17 pm and that it was assigned a response priority of 2.2 = commence

within 72 hours. It also details the case was assigned to [DCF 2] on 4/3/2014 at 1205 PM. Along with the Intake report was a 5 page medical report that appears to have been faxed to DCF emergency services at 9:59:13 PM on 4/2/2014.

8. A review of the medical report associated with intake [Intake 1] shows it was submitted by [Doctor 1]. The first section titled Emesis, begins by detailing the 14 month old child stopped walking 3 days prior to this and that he had previously enjoyed running around the house. It further indicated he is still crawling and was pulling up to stand today and bearing weight evenly, and no limp while crawling. This section further indicates he reportedly had a fever for which Motrin was given and had a decreased dinner and fluid intake the prior night. It also reports that mother had vomited 2 days prior with no symptoms. The review of symptoms show PG was positive for vomiting, with decreased food intake and a subjective fever, and that he was negative for any rashes, swollen joints, limp, cough, retractions, nasal discharge, diarrhea, constipation, and blood in the bowel or bladder. The physical exam shows nothing significant and notes that PG appears to be well developed and well nourished, is active and in no distress. It further details that PG tolerated full range of motion exam of his hips, knees and ankles and that he appeared to bear weight symmetrically with assistance. The report continued and noted the presence of a small bruise on his right shin and the bruising on the neck, one on each side of the trachea at about the level of the hyoid bone and each was about 1-1.5 cm and brown in color. The report continued with the final section, ED Course, describing that the "patient generally appeared comfortable and well cared for". It then indicated that despite the reported vomiting and decreased food and fluid intake he was only mildly dehydrated and was feeding appropriately in the ED. The report outlined that due to the past unexplained bruising they tested to seek possible underlying causes and were not indicative of any leukemic process or marrow failure. The report then attributed the not walking to his stomach illness, "Most likely he has been not walking simply due to feeling unwell due to a GI illness similar to the one that caused his mother's recent emesis". The report then advised that the patient's bruising pattern was odd, with no mechanism provided and that [Doctor 1] could not think of any possible accidental mechanism. The last section of the report detailed his interaction with Nytosha Laforce, and Tyler Chicoine and his report to DCF, including a reiteration similar to his verbal report to DCF that the child was generally "well kempt", well fed and cared for and the parents were appropriate with the child during the exam.

9. On 27 May 2014 myself and Lt. [DCF 4] traveled to the home of [Family Member 1] and [Family Member 2] to conduct an interview with them concerning the history of the PG and his time in DCF custody. After initial introductions I explained that our purpose was to review everything that happened with the case of Nytosha Laforce and PG, leading up

to April 4, 2014 and that we did not want to get into any information or conversation regarding the homicide investigation or the fact that her daughter was arrested for that crime earlier this same date. The ensuing conversation was digitally recorded. (See digital recording for more details)

10. [Family Member 2] first advised that Natasha got pregnant by [Family Member 3] in another state and that this was not planned and there were issues from the start. They had Nytosha come back to the Vermont area to stay with them in South Burlington. He advised she had been living in Chester Vermont and [Family Member 3] was living in New Hampshire. They advised they had made arrangements with probation and parole for that transition to South Burlington to happen. He then advised that shortly after moving to the area she entered into a relationship with [Boyfriend 1] and he began staying at the home as well. [Family Member 2] advised this did not last long as they no longer allowed him to stay in their home. He advised they moved out and got an apartment, shortly before PG was born. They advised that she was not put back in jail while she was pregnant. [Family Member 2] and [Family Member 1] advised that at the time PG was born, Nytosha and [Boyfriend 1] had already lost their apartment and were staying at hotels on welfare vouchers. [Family Member 2] advised they had a car that he and [Family Member 1] had provided at that time.

11. I asked about any drug use or abuse when she was pregnant. [Family Member 1] advised that she was concerned about that and that she was also concerned about abuse by [Boyfriend 1]. She went on to describe an occasion where she observed Nytosha changing and saw no less than 50 bruises all up and down her legs and body and was later told by a friend of Nytosha's that it was from [Boyfriend 1] kicking her repeatedly.

12. They advised that PG was born in January of 2013. They found out the next day that PG was on an incubator and had been born addicted to methadone, and had to be treated for this addiction. [Family Member 2] advised that [Family Member 1] had been doing all the research on the natural treatment and dangers of vaccinations for the child. He advised that she was relating this to Nytosha and [Boyfriend 1] took this to mean he wasn't an adequate provider and confronted [Family Member 1] on this. He advised that after this, they let Nytosha and [Boyfriend 1] know that [Boyfriend 1] was no longer allowed at their home. [Family Member 1] advised that she was purchasing organic formula and foods for the baby. [Family Member 1] advised that Nytosha decided to not have PG vaccinated because she was concerned about the issues as well and that because PG had been born addicted he still needed to detox from all of that treatment. [Family Member 1] advised that she set her and PG up with a naturopathic doctor. [Family Member 2] advised that the reason all this had come up was because they noticed that

from the start PG had always had fast and labored breathing. He then advised that Nytosha had been keeping from them that PG was still on methadone at that time.

13. [Family Member 2] advised that [Boyfriend 1] was on a GPS monitor and he cut off his monitor and he, Nytosha and PG all fled the area to New Hampshire. [Family Member 2] advised that was when [Family Member 1] started making calls to get PG back here in Vermont and spoke with Probation and Parole about her being out of bounds. [Family Member 1] advised that she found something on face book and that Nytosha was in New Hampshire and had said she was going to kill herself and couldn't live like this anymore. [Family Member 1] was told that the photo showed them using heroin again. She advised that the friend who told her about this was a girl named Stacey who lived in New Hampshire. [Family Member 1] advised that this is when she began calling multiple police agencies to get involved and alerting them to the vehicle as well as DCF. Note: These calls to Probation and Parole and direct calls to DCF did result in a DCF intake report [Intake 3], which was accepted as a CHINS B investigation and commenced on 5/24/13. (This was the initial accepted intake which began the state custody of PG)

14. [Family Member 1] advised that New Hampshire Police got on the case pretty quickly and were calling her back and keeping her informed. She advised that at some point Nytosha was arrested and PG was taken into custody and placed in foster care in New Hampshire. [Family Member 2] advised that they were then under the impression that they had to work with DCF to get PG placed with them back here in Vermont. They ultimately went to New Hampshire to get PG. They then brought PG back here and there was an emergency hearing in Vermont, then went through the DCF Kinship Foster care application process and PG was placed with them. [Family Member 2] then advised that the frustrating part of that was every time there was a hearing involving PG they were asked to leave the courtroom and had no input in the process at all. He advised that the lawyer for PG was the only one who sought their input and was the only way they could voice their issues.

15. [Family Member 2] advised that at some point, Nytosha had been moved back to Vermont and was still incarcerated. [Family Member 2] then advised that he and [Family Member 1] wanted DCF involvement so that Nytosha could not manipulate her mother or him into just releasing PG back into her custody. This would hold her to taking steps to take care of her issues but her attorney was fighting that all the way. [Family Member 1] advised that she pushed for the Lund home as an option. She went on to advise that Nytosha had drug issues since 14 or 15 years of age. She advised that she had spoken to Lund and that Probation and Parole was working on this as well, and that the case worker

was [DOC 1]. [Family Member 1] advised that [DOC 1] called her up at one point and advised she was concerned with the therapy Nytosha was receiving at the Lund home and that this was getting changed.

16. They advised that Nytosha went to the Lund Home in July or August. She advised they were told by Lund that she would not be released until she was all finished and better. [Family Member 1] advised that she had been calling the Lund home to tell them about the manipulations of Nytosha and what to watch for. She advised that she had seen Nytosha out of the Lund home with other guys and they would not call her back in this issue. [Family Member 2] then advised that they were made to think that their input was no longer welcomed by the Lund home. He then advised that at this time, DCF began pushing the vaccination issues for PG, because it was DCF policy. [Family Member 2] advised this was the catalyst for Nytosha's attorney to start trying to get custody back to Nytosha.

17. [Family Member 1] then advised that there was one occasion where Nytosha was calling her about issues with PG and needing to go to the ER and this was not being facilitated by Lund. She advised that it finally happened and it was not an issue but she was not impressed with the staff or conditions at the Lund Home. [Family Member 1] advised that Nytosha was always bringing PG into bed with her while at Lund and he was not always sleeping in the crib. They advised that while she was in Lund [Boyfriend 1] was no longer in the picture. They advised that she was still out seeing other guys. [Family Member 1] advised that Nytosha was supposed to be going to NA meetings and they were never sure if this was actually happening or not.

18. [Family Member 2] advised that Nytosha had completed all the Lund courses she was required to before she was granted custody back and that even Nytosha had advised the courses were not what she really needed and were more or less, "Cookie Cutter" courses. They advised that she couldn't get into the relationship course and then when she did get in it was not a course she needed as well. [Family Member 2] advised that she had graduated Lund around Thanksgiving and was still staying there while she was getting a place of her own. [Family Member 1] advised that she had been given custody back and that Nytosha was trying to get a home or got one around the beginning of December. [Family Member 1] advised she was behind the custody return because of DCF pushing the vaccination issues on PG. [Family Member 2] advised this was an issue and that had DCF not made an issue out of the vaccination then PG would have probably stayed in DCF custody and Nytosha would not have pushed to get him back so soon.

19. [Family Member 2] advised that after Lund, Nytosha got her apartment, and that her step father [Family Member 4] had gotten her a car. He then advised she moved into the

apartment on Mallets Bay Avenue. [Family Member 2] advised that all this time Nytosha had a whole network of friends who were helping her maximize her benefits from the welfare system.

20. We then asked about when Tyler came into the picture. [Family Member 1] advised it was around February and that there were a few before him and they were all short lived and mostly drug users. She then advised there was one who seemed very nice and clean and his name was [Friend 2]. She then advised that she would always try to check on the guys Nytosha was with and try to meet them.

21. [Family Member 1] advised that shortly before PG died, Nytosha seemed like she was turning around. [Family Member 2] was over helping baby proof the apartment and that the apartment was spotlessly clean, neat and always picked up and this was out of the ordinary for her. [Family Member 1] advised that this was for a few weeks before PG died and Nytosha was trying to be the "perfect housewife" and trying to have a happy family. [Family Member 1] advised that it appeared that Nytosha was trying to please Tyler. [Family Member 1] advised that she was feeling like something wasn't right and felt a lot of anxiety when she was at the apartment.

22. They advised they had not seen PG within the last week or so before he died. [Family Member 2] advised that the Saturday before he was fine and was running around the house with no issues. [Family Member 2] advised that he was often bringing Nytosha to the clinic on Saturdays and Sundays so he could see PG. [Family Member 2] advised there was nothing different about Tyler on that last time he saw them as well. [Family Member 2] advised that he was aware they were smoking pot in the house as he could smell it all the time when they went to the house. [Family Member 2] then advised that the change they saw in Nytosha and the clean house was all her trying to make the family life seem appealing to Tyler and she really wanted a father for PG. They also advised they had a video of PG from a week and a half before he died and he was fine.

23. [Family Member 2] advised that Tyler had a curfew at his own home and by Probation and Parole and that he really wasn't supposed to be living at the apartment. He advised that Tyler knew when Probation and Parole would be checking on him and he was over at his house for those. He advised that Tyler would always check on her when she was at the Bupenorfin clinic to see when she was coming back. [Family Member 2] advised that he felt a part of that was because Tyler didn't like watching PG.

24. [Family Member 1] advised they were not told about Nytosha and Tyler bringing PG to the hospital and that it wasn't until a day later when Nytosha called freaking out over DCF wanting to do a home visit. [Family Member 2] told her that there is nothing to hide

so don't worry about it. [Family Member 2] advised that it surprised him that DCF would call ahead of time to arrange a home visit, so they can make their house all pretty. They advised the next contact was on Friday when Tyler called advising they had brought PG to the hospital because he wasn't breathing. [Family Member 2] advised that it was very weird at the hospital because Tyler was there saying they have to be able to do something and asked if [Family Member 2] wanted to see PG. [Family Member 2] was under the impression he would be brought into a room to see PG on life support or something. He advised when Tyler brought him into the room, PG was dead. [Family Member 1] advised that the whole time they were at the hospital Nytosha had not stopped crying and Tyler was calm.

25. [Family Member 2] advised that there were so many opportunities to avoid this. He questioned why the hospital released him with the bruises on his neck. [Family Member 1] advised that others were telling them about seeing things about PG they never reported. [Family Member 2] advised that they never seemed to be able to have input through the whole process. This included from DCF, the courts and even from the lawyers involved.

26. [Family Member 1] advised that this all starts with the Hospital and that Nytosha had brought him to the hospital for a reason. [Family Member 2] advised that he was even told that his symptoms were all consistent with head injuries. We then ended our interview of [Family Member 1] and [Family Member 2].

27. On 6 June 2014 myself and Lt. [DCF 4] met with [DCF 1] at the New Haven State Police barracks. [DCF 1] was accompanied by her attorney, [Attorney 1]. We subsequently conducted a sworn taped interview with [DCF 1]. (see digital interview for more details)

28. We first covered the nature of the interview and that this was a voluntary interview on her part. We then went over what we were covering in our interview. She advised that she received the case in July of 2013 after [DCF 6] had left unexpectedly. She advised that when she got the case, Nytosha and PG were living with her mother and arrangements were being made to get them both to Lund. Nytosha was first admitted to Lund and then PG was able to join her at Lund. She advised that the team at Lund was made up of [Lund 1] (Case Manager), [Lund 2] (a Clinician) and [Lund 3] (a para-educator). She advised that there was also someone else who completed the substance abuse assessment.

29. [DCF 1] advised that classes were set up for her and that PG was set up with child care and they began holding status meetings. [DCF 1] advised there were some initial concerns around the drama with other girls at the Lund home and then with Nytosha not engaging in either the classes or the counseling sessions initially. There was nothing that

would make her leave the program but just some concerns. [DCF 1] then advised that as time went on she became engaged and began doing much better in both her classes and counseling. She advised that Nytosha was then referred to services with the Chittenden Center as well and this was arranged with the help of her case manager.

30. [DCF 1] advised that Nytosha was seeing her clinicians and was getting PG to day care and all his appointments. She seemed to be doing very well. She advised that in the fall, Nytosha and her attorney began expressing that they wanted custody discharged back to Nytosha with the agreement that she would continue to stay at the Lund Center. There was a hearing in November of 2013 and there was agreement to allow this custody change to happen. [DCF 1] did advise that it was frustrating at times because she was not always being made aware of the team meetings with Lund. She did clarify that the Lund staff had nothing to do with the Family Court hearings. She then advised that at the hearing in November custody was discharged back to Nytosha. She advised that Nytosha was meeting the needs of PG, she had met her requirements at Lund and she was complying with her treatment and the plan was for her to remain at Lund. She advised that DCF would keep an open family case to monitor her progress.

31. I then asked about the issues surrounding the vaccination issue. She advised that Nytosha was against the vaccinations and the Judge ruled she did not have to have PG vaccinated. [DCF 1] advised that it was DCF policy to have the children vaccinated. [DCF 1] did not recall what stance DCF took at the hearings.

32. I then asked about the issues initially at Lund and if there was violence at that time. She advised that it was mostly arguments and no violence. I then asked about drug testing and [DCF 1] advised that she could not recall any failed tests that she could remember.

33. I then asked about the issues of how DCF can keep an open case after the court has ordered the return of the child. [DCF 1] advised that it was her understanding that she could keep the case open to monitor the progress. She went on to advise that when she visited Nytosha in January of 2014, Nytosha was very upset and stated she believed the case was closed and why was DCF still involved. [DCF 1] advised that it was her understanding they were to keep the case open and they had. [DCF 1] advised that Nytosha was just living at Lund and finishing her program and they had been helping her with her housing. [DCF 1] advised that she only visited her at Lund and never at any outside housing or apartment. [DCF 1] advised that Nytosha was still engaging and answered her questions at this visit.

34. [DCF 1] had no further contact after January 9th 2014. She advised that they had closed their case at that time. She advised that she had met with Nytosha and then advised her

supervisor that the case could be closed. She advised her supervisor was [DCF 8]. She then advised that there would be a 242B form, which is a closing summary and this was not completed in this case. She advised the case summary talks about why DCF was involved, services provided and the events leading up to the case closure. She advised that it was her responsibility to have this form done and it just did not get done. She also advised that it is not uncommon to not get these done in a timely fashion.

35. We then asked about any issues over Nytosha driving while at Lund and she advised she did not recall this. I then asked if she had any concerns about Nytosha's interaction with PG and her mothering ability. She advised that she never had any concerns over these issues. I then asked if there were concerns over any other people in her life that may be care givers to PG and if they needed to be vetted by DCF or in a case plan. [DCF 1] advised that her mother had concerns over someone Nytosha was seeing and DCF was not concerned as this was found to be someone who would not be staying in her life. She advised Nytosha was getting her apartment alone with PG and no other person involved to her knowledge. [DCF 1] advised that she was never even aware of where Nytosha was actually moving to.

36. I then asked about the original reason for state custody. She then advised that it was because Nytosha had gone to jail and PG came into custody and placed with her mother. I then asked if there was any indication PG was taken into custody due to risk of harm or abuse and she advised no and this was not the case. I then asked if her parenting issues ever came up with DCF or at Lund and she advised that parenting issues were never brought up about Nytosha.

37. We then asked about Probation and Parole and she advised the she could not recall any concerns raised by them. She advised they were at the Lund meetings and the status hearings.

38. [DCF 1] advised that Nytosha was able to go through the Lund program faster than most as she was meeting the needs of PG. She further advised Nytosha was making all her meetings and the appointments for PG and that she was completing all her classes. I then asked to clarify what "meeting the needs of the child" actually means. [DCF 1] advised that it was that Nytosha could soothe PG, feed and take care of PG, meet all his appointments, getting to day care, doctors and other issues.

39. We then asked about doctors' appointments. She advised that she did not recall where they were but that they would be his regular checkup appointments.

40. I then asked if she was involved in any of the events after the report of 2 April 2014. [DCF 1] advised that she had no involvement after 9 January 2014. I then asked if she got interviewed by [DCF 5]. She advised that this was about three weeks after the death of PG and part of an internal process. I then asked if during that interview she related that something had been missed or not done in this case. She advised that she did not recall saying anything like that and that the only thing missed was the closeout summary that hadn't been done. She advised that the only other concern was that Lund was not as forthcoming with the case status meetings.

41. We then asked if she had involvement with Nytosha's mother and she advised that she did not. [DCF 1] also advised that she was not aware that [Family Member 1] was frequently calling the Lund program. [DCF 1] advised that she never had to make a home visit to the [Family Member 1] home either. I then asked about the transfer of PG to Lund. She advised that Nytosha went first and then within a week or so PG would have been allowed to join her. [DCF 1] advised that she was not aware of any anger or violence issues between Nytosha and the Lund staff.

42. We then asked about her case notes, and if the first one we had in September was the first visit to Lund. [DCF 1] advised it was not and that the other dates were in her day calendar and that often the case notes are not up to date, and not always entered as they should be. She then advised that she was recently asked about this by her director, [DCF 9]. She confirmed that there were more visits than what was contained within the case notes. She advised the planner notes showed she was there at least once a month. She advised that when she found out we would be interviewing her she asked about whether she should update the case files and notes and he never got back to her.

43. I then asked her about the emails by [DOC 1] over a [Friend 3]. She advised that she did not recall the exact issue and did not recall speaking with Nytosha about him. She did not recall ever hearing from Lund that it was an issue or interfering with her at the program. I then asked about the safety risk assessment of June 2013 and she advised that she did not do that one. She also confirmed that she did not finish any final safety assessment, nor was there a final case plan done in this case. She advised that Nytosha had gone through the progression quicker than most. [DCF 1] advised that she was not even sure if she was ever responsible for writing a case plan in this case. I asked if she was aware if urine screenings for drugs were being done with Nytosha. She advised that either Lund or Probation would have been doing these but she was unsure of any results.

44. I then asked if the outside clinician from the Chittenden Center was ever at the Lund meetings. She advised that they were not and she was unsure why this was not done but that Lund was in contact with the Chittenden Center. I then asked about Nytosha

admitting in open court to having been taken out of the Chittenden program. She advised she was not aware of that and was not at that final hearing. [DCF 1] advised that [DCF 10] covered that hearing for her and was to support the return of custody of PG to Nytosha. I then asked if she was ever asked to make a home visit after Nytosha got housing and she advised that she was not. She advised that Nytosha was always a resident at Lund until after the DCF case was closed out. She also advised that after 9 January 2014 Nytosha had no further contact with DCF. We then completed our interview of [DCF 1].

45. On 6 June 2014 myself and Lt [DCF 4] met with [DCF 2] at the Vermont State Police barracks in Williston. The purpose of this was to conduct an interview of [DCF 2]. At that time he was accompanied by his attorney [Attorney 2]. We subsequently conducted a digital taped interview of [DCF 2]. (See digital interview for more information if needed.)

46. We again went over the scope of this interview and that this was a voluntary interview on his part. He first confirmed that he only became involved after 2 April 2014 and was only peripherally involved in the original case as he was a supervisor. He advised that he supervised [DCF 4] and this was only through the original CHINS hearing.

47. [DCF 2] advised that a report came in on the evening of 2 April 2014 and it was accepted as an assessment and he assigned it himself on Thursday 3 April 2014. It was clarified that this report came into Emergency Services from a Pediatric Resident after hours. He confirmed that he saw that intake report on 3 April 2014 and that he had only seen the intake report and had not seen the medical report.

48. [DCF 2] advised that it was assigned as an assessment and that this gave him 72 hours to commence the investigation and that this was guided by the response priority. [DCF 2] clarified that this assessment priority is designated by the intake screener not by [DCF 2]. At this point I showed him intake [Intake 1] to view as we discussed this response.

49. [DCF 2] advised that he then contacted Nytosha to arrange for a home visit, which was arranged for early afternoon on 4 April 2014. [DCF 2] advised that Policy 52 (on Commencing investigations) indicates they have 72 hours to contact the parent in this case and then 5 days to see the child. [DCF 2] called immediately and was scheduled to see the child within 24 hours of receiving the intake.

50. I then asked about the actual visit to the home. [DCF 2] advised that he arrived shortly after 1 pm and was met at the door by Nytosha and that she was prepared for the visit. He noted Tyler Chicoine was still in a towel and had appeared to have just come out of the

shower. He advised that Nytosha explained that PG was better but not fully well and that he was currently in the other room sleeping. He then advised they discussed the purpose of the visit and then Tyler came back out and he told them both that he had to see PG. He advised they then go to see PG for the first time, within the bedroom. [DCF 2] advised that he observes Tyler has a black eye and asks about it and he explains that he had been boxing with a friend and wasn't careful enough. He advised they went into the bedroom and PG appeared to be sleeping with a blanket up to his clavicles. He reiterates to Nytosha that he has to view the injuries and they walked over to the crib and she gently touches his head and turns him so he can see the bruise on the left side of his neck. [DCF 2] advised that she was very slow and methodical about moving him and got the impression that she did not want to wake PG and then returned his head to straight up and down, as the child was sleeping on his back. [DCF 2] advised that the lighting within the room was very poor and told her that he would need to see the other bruise as well but could do that later after the interview. He advised that they then left the room.

51. [DCF 2] described the apartment as clean but very spartan, and not furnished within the kitchen. He advised they went into the living room and spoke with her about the night at the hospital, her support system and any potential causes of the injury. [DCF 2] advised that Tyler claimed not to be living here and that he has an apartment a short way down the road. Both of them claim not to know how the bruises were caused and that it may be from PG being an active child. [DCF 2] advised that Nytosha was not upset that DCF had been called and both were relaxed and cooperative while he was there and interviewing them.

52. [DCF 2] advised that Nytosha claimed to have noticed the bruises on the day he was brought to the hospital but he is uncertain how she noticed them or if the hospital was the one who pointed them out to her. He advised the interview was only about 20 to 25 minutes and he was at the residence for about 40 minutes. He advised that after the second viewing he was there for just long enough to have Nytosha sign a medical release and that she explained to him that they were switching doctors. Nytosha advised this was because the other doctor was promoting vaccinations and she was not comfortable with that. [DCF 2] advised that there was no actual follow up with the doctors because PG had died.

53. [DCF 2] confirmed that he directly asked Tyler about the bruising as well and he denied knowing how it could have happened. [DCF 2] offered several other possible accidental scenarios and he advised that they continued to advise they had not grabbed him or stopped him in any way that would have caused accidental bruising and they continued to

say they had no explanation for the bruising. [DCF 2] advised that he left the residence at about 1:45 PM. He advised that he never returned back to the house.

54. [DCF 2] advised that he had only had the intake report and had never seen the medical report that had been faxed to the Emergency Services number and I provided this for him to view and he again confirmed he had not seen this. [DCF 2] advised that Emergency Services would have the responsibility to fax the medical report to him if it was needed and that this report should have been faxed to him in this case. He also confirmed that they do get information faxed with the intakes from time to time and they review this prior to beginning the case.

55. [DCF 2] confirmed that if PG had not died, he would have followed up with the doctor and would have probably been back for an additional visit. I then asked [DCF 2] if he would classify the injuries as significant and he advised that he knew the child had been cleared medically and that the only issue was he had no explanation for the injuries. He advised he was not satisfied at this point. [DCF 2] advised that he had not been able to actually listen to the phone call intake from the Doctor.

56. I then had [DCF 2] read page 2 of the intake again. After this I asked him if he had any concern about why PG was brought to the hospital. He advised that he had none. I then asked if he ever knew the information about PG not walking and he advised that he never had that information nor had he ever seen the medical report. [DCF 2] advised that he did interview about this internally already with the Commissioner and Operations Manager. [DCF 2] advised that his case notes did reflect his visit on 4 April 2014. We then ended our interview of [DCF 2].

57. On 18 June 2014 myself and Lt. [DCF 4] conducted an interview of [DOC 1], of Vermont Department of Corrections, Probation and Parole division. This was done in her office on Cherry Street in the city of Burlington and was a digitally recorded interview. (See digital interview for more information if needed.)

58. [DOC 1] advised that she was a probation supervisor for Nytosha Laforce from May of 2013 until November 15th of 2013 and then [DOC 2] took over supervision of her. She advised that [DOC 3] had supervision of her prior to her supervising Nytosha. She then advised that [DOC 3] met with her in early May and then on 24 May 2013 [DOC 1] requested an arrest warrant because Nytosha had fled to New Hampshire with [Boyfriend 1]. [DOC 1] then advised that at that time she also called DCF to report that she thought the child was unsafe at that time. She advised that the basis for this was after calls with [Family Member 1] (mother of Nytosha Laforce) where she was informed that [Boyfriend 1] physically abused Nytosha and possibly PG. [DOC 1] advised that she was

also informed that [Family Member 1] also called DCF as well. (These reports were documented by DCF and accepted as a CHINS report with intake [Intake 3]).

59. [DOC 1] then advised that she again spoke with DCF on 30 May 2013 to begin arranging the transfer of PG to Vermont. She advised that she spoke with Officer [Police 2] and knew that DCF worker was [DCF 4] and that on 3 June 2013 Nytosha and [Boyfriend 1] were arrested in New Hampshire on warrants from Vermont. [DOC 1] then advised that Howard Papineau then spoke with the New Hampshire jail on 5 June 2013 to begin arranging for the transfer back to Vermont of Nytosha Laforce. She then advised that Laforce was brought to Springfield Jail on 13 June 2013. She was then transferred back to Chittenden Jail.

60. [DOC 1] advised that she did get phone calls from [Family Member 1] from time to time, but the calls were about different guys Nytosha was hooking up with and had concerns over to see if these were violations etc. She confirmed that as part of conditions of release she could not associate with [Boyfriend 1]. She advised that this was noted on 5 July 2013 that she not contact [Boyfriend 1] and [Family Member 3].

61. [DOC 1] then advised that on 10 July 2013 she spoke with Nytosha and [Family Member 1]. She advised that this was about issues of Nytosha not being a good parent. [DOC 1] advised that [Family Member 1] had very high standards and that the whole time she was with Nytosha she never saw any parenting issues and saw her to be a good care giver to PG. She did advised there were issues of Nytosha not following her mother's rules while on release.

62. [DOC 1] advised that on 15 July 201, [Family Member 1] went before the parole board to say that Nytosha was doing better and her parole was continued. On 23 July 2013, Nytosha was transferred into the Lund Program. [DOC 1] advised that shortly after this entry into Lund she got an email from Lund stating Nytosha has a compulsive need to socialize and was always asking for outside passes.

63. [DOC 1] then advised that on 8 August 2013, she was at a meeting at Lund and was informed that [Family Member 1] was calling too much and that Nytosha needed to buckle down on structure and the program in general. She advised that the initial start at Lund was a little rocky but she then turned it around after a time and really got on track. She also advised that she got a complaint from [Family Member 1] that Nytosha was seeing 4 guys while at Lund and hooking up with them in the woods behind Lund and not meeting the needs of PG. [DOC 1] advised that she called DCF worker [DCF 1] to be at the next Lund meeting. She further detailed that Nytosha was having problems with her counselor at Lund and they got her another counselor and this seemed to work.

64. [DOC 1] then advised that she received an email from [Family Member 1] over guys Nytosha was involved in and that she may be seeing a male named [Friend 3]. She advised that this was also [Family Member 1] complaining that she didn't think Lund was working.

65. [DOC 1] then advised that as of 30 August 2013 there were still some issues of Nytosha not engaging fully with Lund yet. She advised that this note was from [Lund 1] at Lund.

66. [DOC 1] advised that on 6 September 2013 she received a call from [Family Member 1] over issues regarding vaccinations by DCF and that this is an issue. She advised that at this time they also got Nytosha switched into the Chittenden Clinic and that this helped her engage and move forward. This was confirmed by a meeting on 11 September 2013. They did receive notification of issues of Nytosha with scheduling and missing group time over other meetings.

67. I now asked very pointedly about the actual status at Lund and explained that we have been informed that Nytosha did wonderful at Lund and questioned this, since at this point it was 2 months into her time and all I have heard is issues about her performance. [DOC 1] advised that she knows and that there was something very weird about Lund with Nytosha as she was moving up in her classes and graduating to the next levels but all she heard about was complaints from [Lund 1]. [DOC 1] advised she confronted Lund about this on 1 October 2013 and Lund agreed she was actually doing very well. Nytosha was so concerned about the issues she began having her attorney attend the meetings. She then advised that as of the 9 October 2013 meeting Nytosha had graduated all the way to Green level.

68. [DOC 1] then advised that in a meeting on 4 November 2013 Nytosha was now getting set up with a job and seeking an apartment and trying to move toward the end. She was also trying to get day care set up as well.

69. [DOC 1] then advised that there was a hearing on 6 November 2013 and that the position of Corrections was to support that Nytosha be granted custody of PG fully. [DOC 1] advised that she was at the hearing and there was a male named [Friend 4] there supporting Nytosha. She advised that she came back and checked him in the computer and saw no issues and he was there just as a friend for Nytosha. She then advised that her last case note was 15 November 2013 and that her job stuff was moving forward and she was on the list for an apartment. She then advised that [DOC 2] then took over supervision of Nytosha up until PG died.

70. [DOC 1] advised that she noted that Nytosha had appropriate parenting skills and was meeting appointments for PG and had no issues. She did advise that she was having urine screenings for Nytosha and that there may have been some failed tests but she was unsure how that was handled by Lund. We then asked if a failed drug test would be reported to DCF and she advised that they have been told by DCF that drugs don't rise to the level of calling and aren't much of anything to them. We then ended our interview with [DOC 1].

Case Findings: (The following section of this report details items of interest found within the case files, court transcripts and case review and explanations of this information as well as comparisons to the interviews provided to date.)

71. DCF has provided a timeline of events and information in connection with this case and it begins with PG being born on 10 January 2013 and that PG was born premature and drug exposed (positive for opiates). This timeline note also indicates that no actual report was made to DCF at that time by the hospital. During the interview of [Family Member 1] and [Family Member 2] they revealed that shortly after PG was born and living at their residence, the learned from [Boyfriend 1] and Nytosha Laforce that PG had been born addicted and was on methadone since birth.

72. The next entry concerned a DCF intake report from 22 Mar 2014. This would have been when PG was only about 2 months old. The intake was from a Reach Up worker, who had been facilitating needs for Nytosha Laforce and PG. In review of this intake report, [Intake 4] I noted the call was made to DCF on 3/22/2013 at approximately 1308 hrs. The report detailed that the worker was concerned that Nytosha was not "connecting" with the child. The report details that the worker witnesses that Nytosha is rough with the child and that at birth both mother and child were addicted and that both PG and Nytosha are currently on Methadone. The report indicates that the caller was concerned that the child was not being fed adequately and weighs only 8 pounds now. The caller described that the mother is still using Premie bottles and during a visit this same date became frustrated with the child and stuck and empty bottle in the child's mouth. The caller expressed concern that the mother is out and loose with the child and not complying with Reachup requirements and will be losing half of her grant. The report also indicates that Nyosha is on parole for aggravated assault and has a history of drug use and that despite being referred to housing services that Nytosha has not followed through with this. The last section details that the caller has seen during the last 2 visits that Nytosha is "rough" with PG and that he cries a lot. The caller held the baby and PG was easy to comfort and stopped crying, and that Nyosha did not seem "connected" to PG. The last line indicates the caller is "concerned that this baby is vulnerable and mother is not focusing on baby's needs".

73. This report was not accepted for investigation or follow- up. The Report Acceptance/Response Priority section indicates the following concerning this being not accepted: "information does not meet Chapter 49 acceptance criteria without evidence that mother is not meeting child's needs and that child does not have adequate basic necessities. No previous intakes to indicate a pattern of concern". The second reviewers recommendation was also "not accepted" and indicates there is no indication the child is without proper parental care or has been abused or neglected.

74. The next noted contact DCF had was from 24 May 2013 and this resulted in intake 148250 being taken and accepted for CHINS (B). The timeline information indicates that DCF received calls from the Parole officer for Nytosha Laforce with concerns about a risk of harm to PG due to mom being off her medications and a possible domestic abuse situation. This also indicated the Nytosha may also be in the state of New Hampshire, which would be a Parole violation. DCF also received a call from the maternal grandmother, [Family Member 1], with concerns about the safety of Nytosha, and PG and that she may be using drugs again. DCF verified that there was a warrant for the arrest of Nytosha Laforce and that the address of her was currently unknown.

75. The information was consistent with the information provided by [Family Member 1] in her interview as well as the information from [DOC 1] (see above sections detailing this information from their respective interviews)

76. Review of intake [Intake 3] shows the first call was made by [DOC 1] as the Parole officer for Nytosha Laforce. The report indicates that there are concerns about risk of harm and medical neglect due to possible exposure to domestic violence and possibly being off methadone for both Nytosha and PG. The report details that arrest warrants are being issued for both Nytosha Laforce and [Boyfriend 1]. The report also details past domestic violence as reported by [Family Member 1]. This included violence against Nytosha and allegedly pulling the legs and dragging PG by his legs recently. The report continues with information from [Family Member 1] again stating her concern about past abuse by [Boyfriend 1]. It continues to note how [Boyfriend 1] does not seem comfortable with the child and is volatile. It also details that [Boyfriend 1] and Laforce are "on the run" and that it is unclear if Nytosha has any methadone left and may have possibly relapsed into drug use at this time. This report was accepted and assigned to [DCF 4] of the DCF Burlington office.

77. Review of the Case Determination report completed by [DCF 4] shows that a CHINS affidavit was completed in support of the petition to have state custody of PG. This report also indicates that DCF engaged law enforcement to assist with attempts to locate PG and

Nytosha Laforce. This was done to try and locate them as well as notifying other states of the arrest warrants and situation. DCF was subsequently notified on 30 May 2013 at 1230 AM that Nytosha Laforce had been located and arrested on the active warrant and that PG was also located and taken in to the custody of the state of New Hampshire and placed within a foster home. The report notes that a hearing was held in the matter on 30 May 2013 at the Ninth Circuit – Nashua New Hampshire District Court and custody was continued with another hearing scheduled for 4 June 2013. The report indicates that in her contact with New Hampshire, they would withdraw their custody petition if PG could be placed in state custody within the state of Vermont. This section also indicates that at that time, Nytosha Laforce had asked that PG be placed in the custody of her mother, [Family Member 1]. Contact was made with [Family Member 1] and she was prepared to receive PG and care for PG. [DCF 4] then indicated that she found no compelling reason at that time why [Family Member 1] and her partner [Family Member 2] Jr would not be safe caretakers for PG. This determination included a home visit. The actual ties and residency in Vermont were established for both Nytosha and PG.

78. The Case Determination report also includes the Assessment of Danger and Safety report that was completed on 30 May 2013. This report indicates the only negative issues noted at the time were the drug issues of the mother at birth of the child and that she was unable to meet the needs of the child due to being incarcerated. The Assessment of Risk was also completed in connection with this case on 7 June 2013and was scored as a "high" risk. This was explained that it was due to the age of the child, caretaker not meeting the needs of the child (in jail), drug use of the caretaker and that the caretaker is homeless (in jail). This risk assessment is broken into two sections with the first being a Neglect/Risk of Harm section. This section scored the highest, and it was noted that most of the scores on this were due to age of the child, the issue of the mother being in jail, the drug use prior to birth of PG and no residence. This section noted this was not a current report of neglect or risk of harm and there had been no prior reports or ongoing CHINS. The second section was titled. Physical or Sexual Abuse, Emotional Maltreatment score. This section scored 1 point due to the secondary caregiver ([Boyfriend 1] at this time) had a known drug issue, and one question was unanswered regarding household violence or threats with the past 12 month period. The case determination was that "based on the high risk assessment score and the child being in DCF custody, this worker recommends this case being opened for ongoing services".

79. On 31 May 2013 another report had come in from Reachup services indicating that Nytosha Laforce and [Boyfriend 1] had been arrested in New Hampshire and that PG was placed in Foster care. This report also indicated that the Reachup worker had last seen PG

and Nytosha on 1 May 2013 and that PG "looked good, appeared clean and looked as if he had gained weight". This report was not accepted by DCF as they already had an open case and intake reference the same information.

88. On 22 July 2013 Nytosha Laforce was placed with Lund and a few days later PG was reunited with her and placed in Lund as well. Nytosha now began her treatment and education programs at the Lund home. All the interviews conducted, the DCF case notes and the DCF timeline were reviewed concerning the time that Nytosha and PG spent at Lund. Although some minor issues were noted there were no issues or red flags about Nytosha not being a good parent or being able to care for PG. The interviews and notes bear out that she was initially not engaging fully in the program but then got on board and progressed very rapidly through her educations programs and became engaged with therapy and counseling and was transporting PG to daycare and his medical appointments.

94. On 9 January 2013 [DCF 1] had a final meeting with Nytosha and PG at the Lund Home. She noted that Nytosha was doing well and was on course to be discharged from Lund and get her own housing. This ended the extent of involvement by DCF. It should be noted that this DCF involvement was 2 months after the last court hearing and it is uncertain if DCF had any legal standing to even keep an open case as the custody had been fully discharged by the courts on 4 November 2013.

95. On 2 April 2014 an intake was reported to the DCF emergency number by [Doctor 1] from the hospital. (This intake # [Intake 1]was fully described and detailed in paragraphs 6, 7 and 8 of this report already.)

96. On 3 April 2014 DCF worker [DCF 2] received this intake and made contact with Nytosha Laforce to arrange a home visit for the following date. On 4 April 2014 [DCF 2] responds to the home and commences his visit with Nytosha Laforce, and PG as well as Tyler Chicoine. (This is documented already in the interview of [DCF 2] paragraphs 45-56.) [DCF 2] leaves the home at approximately 1340 hrs on 4 April 2014. Approximately 5 minutes later Nytosha Laforce makes a call to 911 to report that PG is unresponsive. PG is transported to Fletcher Allen Hospital where he is subsequently pronounced dead.

97. The death of PG generates intake #[Intake 2] for DCF and begins a joint investigation by DCF and the Chittenden Unit for Special Investigations into the death of PG.

Conclusions:

98. After a full review of the case files obtained and all interviews conducted in connection with this investigation I have found no apparent probable cause to support any charge for Neglect of a Public Official. This will be further reviewed by both the Chittenden County State's Attroney's office and the Office of the Attorney General.

99. The review of this case revealed a number of facts regarding the progression of the state involvement from the first time PG was taken into custody up until the time of his death. The following information relates to the chronology of events in this case: PG was initially taken into custody by the state of New Hampshire, upon the arrest of Nytosha Laforce on the evening of 29 May 2013.

101. Nytosha Laforce is returned to the state of Vermont, released and she and PG are entered into a program at the Lund Center with DCF monitoring as well as monitoring by the Department of Corrections Parole division. Laforce starts a little slow within the program but then progresses to the highest levels quickly and engages fully with classes and counseling. There are no indications or reports from her time at the Lund Center or while in DCF custody that there are parenting issues or ever a threat to the health or well-being of PG.

104. DCF does keep their case open and conducts one last visit with Nytosha and PG at the Lund Center on 9 January of 2014. They note they are doing well with no issues and DCF closes their case out at this time. Again, it is important to note that PG was no longer in state custody at this time and had not been since 4 November of 2013.

105. 2 April 2014, PG is brought to the Emergency room for gastro-intestinal issues and vomiting. It is reported that he had stopped walking as well. The Pediatric resident notes 2 small bruises on either side of the chin and this prompts him to make a call to DCF emergency line only because he cannot reason an accidental explanation for these bruises. Review of the call and medical notes associated indicate the child appears healthy, doing well and mother and boyfriend are appropriate with the child. This intake was given a low priority (2.2) and would have allowed 72 hours to contact the mother and 5 days to visit with the child.

106. DCF worker [DCF 2] contacts the mother within 24 hours and is at the home for a visit within 48 hours. [DCF 2] is able to only view the child in a crib in a poorly lit room and does view the bruises and interviews Nytosha Laforce and Tyler Chicoine about the possible explanations for the bruising.

107. Within 5 minutes of [DCF 2] leaving the house, Laforce calls 911 reporting the child unresponsive and the child is brought to the hospital and subsequently pronounced dead. This prompted an immediate investigation into the death of PG.

108. A review of the progression and actions of DCF and State officials involved indicate that all reasonable actions were taken throughout the course of this case from May of 2013 all the way through 4 April 2014. There is no indication that anything more should have been done in this case, given the fact pattern known to date. There were no indicators or events during that entire time which would have predicted the events leading to the death of PG.

CASE NUMBER: 14A102352

OFFICER: Lt Brian Miller

LIST OF EXHIBITS:

1. CD of July 1, 2013 parole violation hearing
2. CD of May 7, 2014 parole violation hearing

LIST OF WITNESSES:

1. Probation office [DOC 2], VT Dept of corrections Ph: 863-7449

NARRATIVE:

On 06.13.14 I spoke with [DOC 2] by phone in regard to his supervision of Nytosha Laforce. [DOC 2] advised he took over supervision from [DOC 1] in November 2013. [DOC 2] had no concerns of the welfare of PG when he was in her care. He had concerns when he learned that Tyler Cichonine was dating Nytosha when they were arrested at UVM. He intended to speak with Tyler's Probation officer about their relationship but did not before the death of PG. [DOC 2] advised that the bus strike seemed to be a problem for Nytosha to get to day care and this made her lose her slot. [DOC 2] said he observed PG with her twice and one time was a few days before his death. Nytosha had said that he was ill and he slept the whole time while with [DOC 2]. [DOC 2] advised that when he took over her supervision she was at the Lund home and there was no information that she was using drugs at that time.

On 06.19.14 Probation supervisor [DOC 4] spoke with me and advised that I would not be able to have access to any more information from Nytosha's case file due to a Vermont Statute. He offered that we could get the parole violation hearings of Nytosha as they were public records. I contacted the Vermont Parole Board and they advised they could give me the audio recording of the hearings.

1. 08.20.2009 audio file
2. 12.10.2009 audio file
3. CD of july1, 2013
4. CD of May 7, 2014

I listened to the CDs of the July 2013, May 2014 hearings, and audio files of the two 2009 hearings. There was no information contained that was revealing about events surrounding the death of PG.

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Detective Lieutenant Brian Miller