# THE FLORIDA SENATE

**SPECIAL MASTER ON CLAIM BILLS**

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| DATE | COMM | ACTION |
|---|---|---|
| 1/22/18 | SM | Favorable |
| 01/23/18 | JU | **Favorable** |
| 2/20/18 | AHS | Recommend: Favorable |
| | AP | |

January 22, 2018

The Honorable Joe Negron
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 18** – Senator Oscar Braynon II
**HB 6509** – Representative James Grant
Relief of C.M.H.

## SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR $5,000,000 PREDICATED ON THE ENTRY OF A JURY AWARD IN FAVOR OF CHRISTOPHER HANN AND THERESA HANN, INDIVIDUALLY, AND AS NAUTRAL GUARDIANS OF C.M.H., A MINOR CHILD, DUE TO THE NEGLIGENCE OF THE DEPARTMENT OF CHILDREN AND FAMILIES.

FINDINGS OF FACT:

The Department of Children and Families, placed J.W., a 10 year old foster child with a history of violence and sexual assaults against younger children, in the home of Christopher and Theresa Hann. The Hanns had young children of their own, and because the Hanns were not trained to handle a child with J.W.'s propensity for violence, the department should not have placed J.W. in the Hann's home. Making matters worse, the department concealed J.W.'s violent past from the Hanns when it had a duty to disclose it. Ultimately, the department's placement of J.W. in the Hann's home led to the emotional, physical, and sexual abuse of C.M.H., the Hann's 8 year old son, by J.W.

**The Department of Children and Families knew of J.W.'s propensity for violence toward other children.**

J.W. was born January 23, 1992, in Florida, to a teenage mother who had a history of mental illness and homelessness. She did not receive prenatal care and attempted suicide during the third month of her pregnancy by inhaling butane. J.W.'s mother was living in a shelter for homeless and runaway youth at his birth. J.W.'s biological father had a history of drug abuse and played no major role in his life.

J.W. lived with his mother until the age of 4. During this time, he was subjected to extreme neglect, cruelty, and physical and sexual abuse by his mother, her boyfriends, and her extended family members. J.W., at age 1, was subjected to sexual abuse for approximately 2-3 years by males visiting his mother. He was severely beaten at age 2 while in the care of his mother's boyfriend.

As a result of his repeated abuse and neglect, J.W. began to exhibit symptoms of post-traumatic stress disorder. Due to aggressive behaviors, he was dismissed from two daycare centers. At age 3, he attempted suicide. He was subsequently diagnosed as having attention deficit hyperactivity disorder with psychotic behavior and suicidal tendencies and treated with anti-psychotic medication.

J.W. was returned to his mother's care at age 5. He was severely psychotic and began setting fires. In June 1997, J.W. was admitted to the Columbia Hospital Inpatient Psychiatric Program for a week due to self-mutilation, violent behavior, homicidal ideation, auditory hallucinations, and multiple suicide attempts. J.W. would continue receiving intensive outpatient psychiatric treatment for 7 months following his initial hospitalization.

After receiving a report that J.W. was again sexually molested by another of his mother's male friends, the department placed J.W. back into foster care where he resided on and off for approximately 5 years. He was involuntarily hospitalized at least two more times by age 9. One hospitalization was due to aggressive behavior, an attempt to stab his uncle and his babysitter with a knife. Later he was hospitalized for planning to bring a gun and knife to school to kill a teacher and himself. In 2002, J.W. was living with his mother who had married several years earlier and had given birth to a daughter with

her new husband. The department and the family entered into a voluntary case plan to address continuing allegations of abuse, neglect, and domestic violence in the home. During this time, J.W. began to exhibit sexually aggressive behavior towards other children. Multiple reports indicated that J.W. performed anal penetration on a neighborhood girl. He also continued to display severe psychotic behavior. On one occasion he attempted to cut his stepfather's throat while he slept.

On June 14, 2002, DCF family services counselor, Suzy Parchment, referred J.W. to Camelot Community Care, a DCF provider of child welfare and behavioral health services, for intensive therapeutic in-home services. Realizing the severity of J.W.'s behavior, in a communication with Camelot on June 24, Ms. Parchment noted that J.W. needed to be in a residential treatment facility as soon as possible.

As an emergency, temporary solution and noting that J.W. was a danger in the home, Camelot accepted the referral to provide mental health services to J.W. in his natural home while the department sought residential placement. Camelot noted on its admission form that J.W. was a sexual predator and engaged in sexually inappropriate behavior. It was also noted that J.W. suffered from non-specified psychosis, major depression with psychotic features, adjustment disorder and attention deficit hyperactivity disorder. The in-home counselor assigned to J.W.'s case did not have experience with sexual trauma, and Camelot's initial treatment plan did not include any specific goals or specialized treatment for sexual abuse.

J.W.'s mother informed Camelot and the department that J.W. was giving his 3 year old sister hickies, bouncing her on his lap in a sexual manner, and having her fondle his genitals. Camelot performed a child safety determination and found that based on J.W.'s history, a sibling was likely to be in immediate danger of moderate to severe harm if J.W. was not supervised. Camelot recommended that J.W.'s parents separate him from his younger sister at night and closely watch him when he interacts with his sister.

On or about August 2002, the department removed J.W. and his younger sister from their mother's care after she abandoned them at a friend's house. J.W. was sheltered in the home of a family friend, Luz Cruz, a non-relative

placement while his younger half-sister was placed with family members.

J.W. underwent a Comprehensive Behavioral Health Assessment on August 30, 2002, at the request of DCF. The assessment concluded that J.W. "should not have unsupervised access to [his younger sister], or to any younger, or smaller children wherever he resides." The Assessment also states: "***J.W.'s caregiver must be informed about these issues and must be able to demonstrate that they can provide adequate levels of supervision in order to prevent further victimization. These issues should be strongly considered in terms of making decisions about both temporary and long term care and supervision of J.W.***"

Based upon the findings and recommendations in the Assessment, J.W. was referred to Father Flanagan's Boys' Home d/b/s Girls and Boys Town, a DCF service provider, for case management services.

**The Department of Children and Families knew that J.W., should not have been placed in a home with younger children.**

Ms. Parchment removed J.W. from the Cruz home on September 6, 2002, due to allegations of sexual abuse by a member of the Cruz family; however, she did not report the abuse allegation as required by Florida law. It was also on September 6, 2002, that J.W. was placed with the Hanns.

Mr. and Mrs. Hann were former neighbors of J.W. and his natural family. The Hanns lived with their two children, a daughter, age 16, and a son, C.M.H., age 8. They were not licensed or trained foster parents. In the past, J.W. had often sought shelter in the Hann home when left alone by his mother. Theresa Hann had offered to care for J.W., and his mother lobbied Camelot and the department to have J.W. placed with the Hann family instead of Luz Cruz.

Ms. Parchment recalled her first impressions of the Hann family were of nice people who maintained a very organized and clean home. She believed Theresa Hann's main purpose was to care for J.W. and that she had no ulterior motives. However, despite the willingness of the Hanns to care for

J.W., the removal of J.W. from the Cruz home and placement in the Hann home violated DCF rules.

Under the department's rules, it is required to obtain prior court approval for all non-relative placements. This requirement eliminates non-relative placements for use in lieu of emergency shelter care. Ms. Parchment did not obtain the required court approval prior to placing J.W. in the Hann home. She also failed to notify the department's legal team, who is responsible for court filings, of the allegation of sexual abuse of J.W. in the Cruz home or his subsequent placement in the Hann home for two months.

Additionally, the placement directly conflicted with previous recommendations by department providers regarding placement for J.W. due to his sexually aggressive behaviors. J.W. was placed in a home with an 8 year old child even though 2 months earlier Camelot had warned that a sibling would be in danger in a home with J.W. One week prior to the placement, St. Mary's Medical Center had recommended that J.W. not have unsupervised access to younger children. The Hanns were not provided any information about J.W.'s ongoing inappropriate behavior with younger children and the Hanns allowed J.W. to share a bedroom with their son, C.M.H. Department rules expressly prohibit placing a sexually aggressive child in a bedroom with another child. Ms. Parchment knew of the planned sleeping arrangements prior to placing J.W. in the Hann home but did not tell them that the arrangement was prohibited under the department's rules.

**The Department of Children and Families failed to inform the Hanns of J.W.'s background.**

Christopher Hann specifically requested information about J.W., but the department failed to provide any information regarding J.W.'s troubled history of child-on-child sexual abuse or on his background generally. Florida law requires DCF to share psychological, psychiatric and behavioral histories, comprehensive behavioral assessments and other social assessments found in the child's resource record with caregivers. The department acknowledged during litigation that no evidence of a child resource record for J.W. was found. Additionally, for the purpose of preventing the reoccurrence of child-on-child sexual abuse, the department must provide caregivers of sexual abuse victims and aggressors with written, complete, and detailed information and strategies

related to such children, including the date of the sexual abuse incident(s), type of abuse, type of treatment received, and outcome of the treatment in order to "provide a safe living environment for **all** the children living in the home."

Not only did the department fail to comply with its own requirements, Ms. Parchment told Mr. Hann that she was not allowed to give him such information about J.W. because the placement was temporary. Nevertheless, J.W. remained in the Hann home for approximately 3 years during which his behavioral problems continued and quickly escalated.

**The Department of Children and Families knew it should have removed J.W. from the Hann home as his violent behaviors increased.**

Within a few weeks after J.W.'s placement in the Hann home, Mrs. Hann reported to Camelot that J.W. was playing with matches in the presence of C.M.H.; exhibited extreme anger and hostility towards C.M.H., including yelling, screaming "shut up" at the smallest aggravation or noise, and kicking C.M.H. Among J.W.'s behavioral problems, he stabbed himself with a straightened paper clip after being grounded for leaving the neighborhood without permission; threatened to jump out of a window after it was discovered he stole a roll of felt from school; and attacked Ms. Hann, biting and scratching her when she grounded him for cursing.

Camelot recommended to Ms. Parchment that the Hanns place a one way monitor in the bedroom shared by J.W. and C.M.H. While Ms. Parchment agreed to pass the recommendation on to the Hanns, there is no evidence that the information was shared or that the Hanns ever obtained the monitor.

J.W.'s behavior further deteriorated and on October 24, 2002, after a physical altercation with C.M.H., he pulled a knife on the younger child but was stopped from further assaulting him by Mr. Hann. Camelot was immediately informed of the incident by Mr. Hann, and J.W. was again involuntarily committed into Columbia Hospital for a mental health assessment. Camelot's notes indicate Ms. Parchment was informed of J.W.'s escalating behavior in the Hann home. Ms. Parchment later acknowledged that at this point she should have considered removing J.W. from the Hann home due to the danger he posed to himself, the Hanns and their son.

A week after the mental health assessment was performed, J.W. sexually assaulted a 4 year old girl who was visiting the Hann home. The children were watching a movie when J.W. exposed his genitals and began "humping" the young girl. Ms. Hann reported the incident to DCF. During the course of the investigation, the department learned the children were not under the direct supervision of any adult at the time of the incident – a failure that DCF providers warned would lead to harm of other children when left alone with J.W. Again, DCF was required to give immediate consideration to the safety of C.M.H. Despite, the inability of the Hanns, who both worked outside the home, to adequately supervise J.W. and his continuing access to young children, DCF did not remove J.W. from the Hann home.

Camelot began pressuring Ms. Parchment to schedule a psychosexual evaluation of J.W. which she was required to do months earlier pursuant to DCF's operating procedures. The evaluation had in fact been requested by Camelot when J.W. was placed with the Hanns and again just 2 days before he sexually assaulted the 4 year old girl visiting the Hann home. Camelot's notes indicate that it told Ms. Parchment that "[J.W.] needed specific sexual counseling by a specialist in this area." Ms. Parchment took no action so Camelot advised Mr. Hann that a new safety plan would be implemented which prohibited J.W. and C.M.H. from sharing a bedroom and requiring J.W. to be under close adult supervision when other children were present. Such recommendations had already been a complete failure at preventing J.W. from perpetuating sexual abuse on other children. Further, still without knowledge of J.W.'s extensive history of sexual abuse as a victim and aggressor, Mr. Hann informed Camelot that the family disagreed with and would not follow the safety plan.

**The Department of Children and Families ignored repeated warnings from its service providers.**

Beginning in November 2002, Girls and Boys Town began providing services to J.W. in conjunction with Camelot. The assessment of J.W.'s case and his current behaviors, which was performed by Girls and Boys Town, found that despite his escalating violence and suicidal and sexually aggressive actions, no additional interventions or therapies had been put in place.

Camelot again requested a psychosexual evaluation of J.W. on November 6, 2002.

Additionally, in November 2002, C.M.H. began to exhibit behavioral problems which Camelot directly attributed to J.W. being in the home. C.M.H.'s grade dropped. In one school year he went from being an "A", "B", or "C" student to failing grades and was ultimately retained in the fourth grade.

In December 2002, the Hanns, overwhelmed with the number of providers involved in J.W.'s care and the disruption to their family, canceled the services of Camelot. Camelot recommended in its discharge form, signed by Ms. Parchment, that J.W. be placed in a residential treatment facility; however, DCF did not initiate a change in placement.

In June 2003, J.W. began expressing sexually inappropriate behavior towards C.M.H., asking him if he wanted to "see what sperm looks like" before masturbating to completion in front of him and attempting to hand him the semen. Due to this new escalation of J.W.'s behavior now directed at C.M.H., the department finally secured the psychosexual evaluation of J.W. but still did not remove him from the Hann home.

The department received the results of the psychosexual evaluation of J.W. performed by The Chrysalis Center on September 18, 2003. The Center found that J.W. "fit the profile of a sexually aggressive child due to the fact that he continues to engage in extensive sexual behaviors with children younger than himself." Further, it was found that J.W. "[presented] a risk of potentially becoming increasing more aggressive" and "continuing sexually inappropriate behaviors." The Center warned that J.W. "may seek out victims who are children and coerce them to engage in sexual activity." And again the Center recommended specific counseling for J.W. and appropriate training for his caregivers, the Hanns.

Finally, in October 2003, the Hanns requested J.W. be placed in a therapeutic treatment facility as they did not feel equipped to provide him with services and interventions he needed. Therapeutic placement was authorized for J.W. and he was referred to Alternate Family Care in Jupiter, Florida. The Hanns were told that if J.W. was removed from their home they would not be permitted visitation privileges with him at the facility. The Hanns did not want to be the next in a series

of parental figures that abandoned J.W. so they ultimately made the decision to maintain him in their home with a request for additional services to treat his ongoing issues. At this time the Hanns begin training to become therapeutic foster parents.

C.M.H.'s problems due to J.W.'s presence in the home continued at school. Beginning in late 2003 to early 2004, C.M.H. began to act out and have more conflicts in school. He received a student discipline referral for ongoing behavioral problems in the classroom. Additionally, in early 2004 he began gaining weight and would subsequently gain about 40 pounds over the next two years.

**The Department of Children and Families failed to remove a dangerous child it had placed in the Hann home when requested by the Hanns.**

Mrs. Hann was diagnosed with terminal cancer on March 3, 2004. As a result, Mr. Hann contacted DCF within 48 hours of the diagnosis and requested the process of having J.W.'s placement with them as "long-term non-relative care" be stopped and asked that J.W. be placed elsewhere. Ms. Parchment visited the Hann home within 24 hours after the request and advised the family that "we'll get on it."

Nothing was done and contrary to the express request and wishes of the Hanns and without their knowledge, DCF had the Hanns declared as "long term non-relative caregivers" of J.W. The department subsequently closed the dependency case, leaving J.W. in the care of the Hanns.

**The Department of Children and Family Services withdrew support for the Hann family when it was needed most.**

The Hanns were not part of the foster care system so when DCF closed its dependency case, the Hann family lost approximately 50 percent of their services and counseling. Father Flanagan's suspended services to J.W. and the Hann family in April 2004. The Hanns would later directly attribute the resurgence in J.W.'s inappropriate sexual behavior to the loss of counseling services.

With almost no support from DCF, the Hanns grew more desperate as they tried to deal with Mrs. Hann's illness and J.W.'s escalating behavior.

C.M.H.'s troubles also continued. An April 2005 treatment plan from St. Mary's Child Development Center's Children's Provider Network noted that he began to have nightmares and was easily frustrated. The report also noted that his mother's diagnosis of terminal cancer and intensive chemotherapy treatments were contributing to C.M.H.'s increasing separation anxiety and grief issues. He was diagnosed with post-traumatic stress disorder.

In April 2005, Mr. Hann wrote DCF and the juvenile judge requesting help in placing J.W. in a residential placement. There was no response to his request, and J.W. remained in the Hann home.

A report from Child & Family Connections, the lead agency for community-based care in Palm Beach County, dated June 16, 2005, provided a description of J.W.'s personality and behavior, the high risk of sexual behavior problems and increasing aggression, his excessive masturbation, seeking out younger children, lies, and refusal to take responsibility for his actions. The report stated that the Hanns "[had] been told that it is not a matter of will J.W. perpetrate on their son again, but a matter of when the perpetration would occur. [J.W. was] in need of a more restrictive setting with intensive services specializing in sexual specific treatment." The report also noted that J.W.'s previous therapist, current therapist, and a psychosexual evaluation all recommended a full-time group home facility specializing in sexual specific treatment. The report concluded that J.W.'s condition was "so severe and the situation so urgent that treatment [could not] be safely attempted in the community."

**Predictably, the numerous failures of the Department and its Family Services resulted in the sexual assault of another child.**

On June 29, 2005, after a physical altercation between J.W. and Mrs. Hann, C.M.H., then 10 years old, told his parents that 2 years prior, J.W. had forced him to engage in oral sex while the boys were at a sleepover at this cousin's house. Mr. Hann called Girls & Boys Town and demanded that J.W. be removed from the home immediately. Later that same day, the department finally removed J.W. from the Hann home, and he was taken to an emergency shelter until a placement could be determined.

The court entered an order on August 11, 2005, authorizing the placement of J.W. into a residential treatment center. The court found that although a previous court order authorized placement in a specialized therapeutic group home, due to another incident that occurred while in emergency shelter, J.W. required a higher level of care.

Theresa Hann passed away the next year shortly after initiating litigation against DCF and its providers.

CLAIMANT'S POSITION:

The lawsuit was filed against the department, Camelot Community Care, Inc., Elaine Beckwith, Chrysalis Center, and Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida. The suit alleged the defendants were negligent and directly liable for the injuries suffered by C.M.H. as a result of the sexual abuse due to:

1. The initial placement of J.W. in the Hann home;
2. The failure of DCF to follow its own rules and operating procedures to provide the necessary treatment and services for J.W.;
3. The failure of DCF to provide the required information to the Hanns regarding J.W.'s history of sexual abuse and sexual aggressiveness, including the failure to formulate a safety plan for J.W. and all the children residing in the Hann home;
4. The failure of DCF to maintain the safety of J.W. and any children residing in the placement;
5. The failure of the DCF employee to report the allegations of sexual abuse of J.W. as mandated by s. 39.201, F.S.; and
6. DCF moving forward with having the court declare the Hanns "long-term non-relative caregivers," closing the case file, and leaving J.W. in the custody of the Hanns without notice to them and despite their request to stop the process.

RESPONDENT'S POSITION:

The Department of Children and Families defended the lawsuit. On November 18, 2013, after a 4-week jury trial, a judgment was entered in the amount of $10,000,000. DCF was found to be 50 percent liable ($5,000,000) and Mr. and Mrs. Hann were found to be 50 percent liable ($5,000,000). The jury attributed no liability to the remaining defendants.

CONCLUSIONS OF LAW:

Every claim bill must be based on facts sufficient to meet the preponderance of evidence standard. With respect to this claim bill, which is based on a negligence claim, the claimant proved that the state had a duty to the claimant, the state breached that duty, and that the breach caused the claimant's damages.

**Duty**

The Department of Children and Families had a duty pursuant to exercise reasonable care when placing a child involved in child-on-child sexual abuse or sexual assault in substitute care; to provide caregivers of children with sexual aggression and sexual abuse with written, detailed and complete information of the child's history; to establish appropriate safeguards and strategies to protect all children living in the foster or temporary care; to ensure the foster family is properly trained and equipped to meet the serious needs of the foster child; and to exercise reasonable care under the circumstances.

**Breach**

A preponderance of the evidence establishes that DCF breached its duties by failing to follow its governing statutes, rules, and internal operating procedures by:

- Placing J.W., a known sexually aggressive, severely emotionally disturbed, and dangerous child in the Hann home without legal authority and in direct conflict with recommendations of DCF service providers that J.W. not have access to young children;
- Failing to ensure that Mr. and Mrs. Hann were duly licensed and trained as required by department rule, making them capable of safely caring for a child with J.W.'s extensive needs;
- Failing to fully and completely inform the Hanns of J.W.'s history, and the risk and danger he posed to C.M.H. as required by department rule; and
- Failing to remove J.W. from the Hann home when it became clear that the placement was inappropriate and dangerous to the Hanns and C.M.H. particularly.

**Causation**

The sexual, physical and emotional abuse suffered by C.M.H. was the direct and proximate result of DCF's failure to fulfill its duties regarding the foster placement of a known sexually aggressive child.

**Damages**

At the conclusion of a 2-week trial, the jury found DCF and Mr. and Mrs. Hann each 50 percent responsible for the negligence that resulted in the injuries suffered by C.M.H. The jury awarded C.M.H. $6 million for past pain and suffering, $3.5 million for future pain and suffering, $250,000.00 for future treatment and services and $250,000.00 for future loss of earning capacity for a total award of $10 million. The department and Mr. and Mrs. Hann were each responsible for $5 million. The jury did not assess any liability for negligence against the remaining 6 defendants.

C.M.H. was initially diagnosed with post-traumatic stress disorder in 2005. Thomas N. Dikel, Ph.D., reaffirmed the diagnosis in 2010, finding that C.M.H.'s severe PTSD was cause by his "experiences of child-on-child sexual abuse, exacerbated and magnified by his mother's diagnosis of stage 4, metastatic colon cancer."

He was re-evaluated by Dr. Stephen Alexander in October 2014. Dr. Alexander found C.M.H. to continue to suffer from PTSD and major depression, but had become even more dysfunctional since his initial evaluation due to lack of services. Dr. Alexander attributed the majority of C.M.H.'s psychological trauma to this mother's illness and death; however, he did note that due to J.W.'s presence in the home during her illness, the two events have become inextricably intertwined in this psyche.

Comprehensive Rehabilitation Consultants, Inc., created a life plan for C.M.H. to determine the funds necessary to provide the support needed by C.M.H. as a direct consequence of the sexual abuse he experienced. It was determined the cost for medical, psycho-therapies, educational and support services as well as ancillary services of transportation, housing and personal items would be $2.23 million over C.M.H.'s life.

As a result of the judgment entered by the court against DCF, the state paid $100,000 (the maximum allowed under the state's sovereign immunity waiver) with the remaining $4.9 million to be paid if this claim bill is passed by the Legislature and signed into law by the Governor.

COLLATERAL SOURCES OF RECOVERY:

Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida (Father Flanagan) was a named defendant in the lawsuit. Father Flanagan executed a settlement agreement with Claimants on July 30, 2013, in the amount of $340,000. However, in October 2013, the jury found that Father Flanagan was not negligent for any loss, injury or damage to C.M.H.

ATTORNEYS FEES:

Claimant's attorneys have acknowledged in writing that nothing in excess of 25 percent of the gross recovery will be withheld or paid as attorneys' fees.

RECOMMENDATIONS:

The negligence of the department and the Hanns were the legal proximate cause of the damages suffered by C.M.H. However, the jury award of $9.5 million for non-economic damages or pain and suffering is not supported by the weight of the evidence. According to Dr. Alexander's October 2014 report, C.M.H. continues to suffer from PTSD but attributes a majority of C.M.H.'s psychological trauma to the illness and death of his mother. The department should not be held financially liable for C.M.H.'s psychological trauma that occurred due to the illness and death of his mother.

Damages awarded by the jury in the amount of $500,000 for future treatment and services and lost wages due to the sexual abuse are reasonable under the circumstances and are fully supported by the weight of the evidence. C.M.H. requires intensive and long-term psychotherapy, psychiatric evaluation and treatment and possible psychotropic mediations to assist him in dealing with his PTSD.

It should be noted that since receiving the settlement from Father Flanagan's in 2013, C.M.H. has only sought psychiatric treatment one time.

Accordingly, I recommend that SB 18 be reported FAVORABLY, with the amount to be paid amended to $2.5 million. The jury awarded $9.5 million ($4.75 million assessed to DCF) for past and future pain and suffering. Based on a lack of objective evidence in the record, a 50 percent reduction of DCF's obligation or $2.375 million may be a more appropriate amount to be paid for the non-economic damages. A corresponding reduction of 50 percent of DCF's share of the economic damages ($125,000) would be appropriate.

I further recommend that the funds be paid into a trust established for C.M.H. in equal installments over 10 years to pay for expenses related to education, psycho-therapies and living expenses. Any funds remaining in the trust after 10 years should be distributed in full to C.M.H.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

cc: Secretary of the Senate