THE FLORIDA LEGISLATURE

KEN PRUITT
President of the Senate

MARCO RUBIO
Speaker of the House of Representatives

DATE	COMM	ACTION
4/19/07	SM	Fav/1 amendment

April 19, 2007

The Honorable Ken Pruitt
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

The Honorable Marco Rubio
Speaker, Florida House of Representatives
Suite 420, The Capitol
Tallahassee, FL 32399-1300

Re: **SB 2968 (2007)** – Senator Tony Hill
Relief of the Estate of Martin Lee Anderson

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR $5 MILLION ARISING FROM THE SUFFOCATION DEATH IN THE BAY COUNTY BOOT CAMP FOR JUVENILE OFFENDERS OF 14-YEAR-OLD MARTIN LEE ANDERSON. THE MATTER WAS SETTLED WITH ALL PARTIES. THE STATE'S PORTION OF THE SETTLEMENT IS $5 MILLION. $200,000 HAS ALREADY BEEN PAID PURSUANT TO THE STATUTORY CAP, LEAVING $4.8 MILLION TO BE PAID VIA THIS CLAIM BILL.

FINDINGS OF FACT:

Martin Lee Anderson was a healthy, 14-year-old boy who lived with his mother and step-father in Panama City. He was in the 9th grade at Emerald Bay Academy, and he worked part-time with his mother at Burger King. On June 12, 2005, he and several other youths stole his grandmother's car from the church parking lot and were arrested and charged with grand theft auto (a first degree felony) and committed to the Department of Juvenile Justice. January 5, 2006 was his first day at the juvenile boot camp

operated by the Bay County Sheriff's Office pursuant to their contract with the Department of Juvenile Justice (DJJ or the Department).

The incident that led to Martin's death occurred on January 5, 2006. It was his first day at the boot camp. He arrived early that morning and with a group of other boys underwent the customary procedure followed at intake: a strip search, shower, and physical assessment. The purpose given for the physical assessment was to determine each boy's physical abilities so that progress and improvement could later be gauged. The assessment involved counting the number of push ups and sit-ups each boy could do in a 2 minute period, and a 1.5 mile run. The evidence indicates that Martin completed 18 push ups and 48 sit-ups. He was not reported to have shown any physical distress during this part of the assessment.

After finishing about 10 of 16 laps around the exercise yard, it is reported that Martin told Sgt. Garrett, "This is bullshit." Two other officers, Hall and Walsh, placed Martin against the wall of the compound for "counseling." After this counseling, the officers released Martin and he resumed the run.

Shortly afterward, Martin dropped or collapsed to the ground, an event which was clearly recorded by the camera filming the assessment.[1] Martin was then surrounded by officers, at some points as many as seven. They held him by the arms, sometimes against a pole, sometimes taking him to the ground. At least once, the camera records an officer kneeing him in the thigh. The reason given for this in the Protective Action Reports (PAR) is that Martin resisted being examined by Nurse Schmidt, who was in attendance throughout the assessment and throughout the assault on Martin. However, the video shows that in the moments before the knee strike, the nurse was on the other side of the pole against which Martin was pinned at the time making no effort to examine him. Thus, the reason for the knee strike is unexplained. Ostensibly, knee strikes and the other blows and pressure points administered to Martin during his ordeal were said to be justified because he offered some form of physical resistance. For instance, on at least one occasion,

an officer is clearly visible striking Martin's forearm with a hammerfist blow. The reason given for such a blow was that Martin balled his fist. Balling of the fist was viewed as an aggressive act and, from the 174 PAR reports we reviewed, that motion often provoked a hammerfist or another use of force (such as a pressure point behind the ear).

The video, however, does not show Martin offering any physical resistance. At the time of the hammerfist blows, he was lying on his stomach with an officer on each arm, pinned to the ground. It is unclear to the Special Masters how Martin presented a threat from balling his fist in these circumstances. In fact, from the time Martin collapsed or dropped to the ground, he appears flaccid and unresisting. Nonetheless, the officers struck him and applied the pressure point behind the ears numerous times, claiming that he tensed, tried to pull away, or otherwise resisted them. We find there is competent and substantial evidence that Martin did not resist (if he did so at all) sufficiently to justify the blows and pressure points he suffered.

Officers also administered ammonia to Martin from capsules they broke and held under his nose. These capsules were bought by the nurse from a local drug store for placement in the camp's first aid kits. However, before every physical assessment, the nurse gave capsules to camp supervisors, who carried them during assessments. The reason given for applying ammonia capsules was that boys often fainted, grew faint, or faked fainting in order to get out of the exercises. Then, a capsule would be broken under the boy's nose, purportedly in an effort to revive him. Often the boy's mouth would be held shut so that he inhaled a full dose of ammonia and could not move his head away. The nurse knew that ammonia was being administered in this fashion. She provided no training to the officers on how to administer ammonia capsules, nor intervened when they did so in this manner.

Although the claimants asserted capsules were thrust up Martin's nose, there is no medical evidence that this occurred. However, the video clearly shows capsules held directly under his nose.

It is unclear how many times ammonia was administered to Martin. The PAR reports on the incident and the statements taken from the officers are not consistent. These materials indicate from three to five administrations. The video clearly shows three administrations of ammonia. The first occurred for about a minute. It appears that Martin's chin, rather than his mouth, was held fast at that time. He appears to have his mouth closed, although not forcibly. The other two administrations occurred a short time later. They happened back to back so that it appears Martin was forced to inhale ammonia almost continuously. His mouth was held shut during these administrations, and he can be seen struggling and swaying while he is held and forced to breathe the ammonia. The appearance of these administrations is quite brutal and hard to watch. These two administrations lasted at least 3 minutes and perhaps as long as 4 minutes. It is hard to tell about the last minute because one of the officers stands between the camera and Martin, who by this time had collapsed to his buttocks to be held up only by officers grasping each of his arms. Lt. Helms, who was administering the ammonia at this time, said in his statement that he continued to do so and that moments after he released Martin, the boy collapsed on his back, unresponsive, eyes open and filled with sand, which provoked Helms to ask the nurse to examine him. When she did so, she found his pupils unresponsive, which led her to summon an ambulance. Thus, the evidence supports a finding that Martin was forced to breathe ammonia fumes from a capsule held under his nose with his mouth clamped shut for 4 minutes, but certainly not less than 3 minutes.

Medical Intervention

The EMT's arrived within 3 minutes of being called. Chelsea Pollock, one of the paramedics at the scene, testified that when she arrived Martin was face down in the dirt, with several drill instructors surrounding him, as well as the nurse. The paramedics were told that Martin "fell out" after completing push ups, sit-ups, and the mile and a half run, and were informed that there was no trauma; she reported seeing no blood. The paramedics were not told of the force used, the ammonia used, nor that Martin's mouth was held

shut. The ambulance arrived at Bay Medical Center 3 minutes after leaving the boot camp.

Bay Medical Center's emergency room notes state that Martin was brought in from the boot camp, where he collapsed after 15 minutes of physical activity and that one ammonia capsule was used, after which it is reported that Martin became completely unresponsive. Martin remained unresponsive at Bay Medical Center, and the medical staff was unable to diagnose a reason for his condition. After an unsuccessful attempt to intubate him orally, he was intubated nasally. Martin was noted to have no gag reflex. He was quickly transferred by life flight to Sacred Heart Hospital in Pensacola, for which his mother signed the transfer papers.

Sacred Heart Medical Center assessed Martin who was still unresponsive, in respiratory distress, and unresponsive to painful stimulus. The history notes indicate that a sheriff's deputy indicated that Martin collapsed at boot camp and was unable to be aroused with ammonia caps. There is no history note indicating that the medical staff had any knowledge of any of the use of force techniques used on Martin, or the number of times ammonia had been used, or that his mouth had been covered numerous times and for lengthy periods. The physicians at Sacred Heart noted the lack of a measurable blood pressure and that he continued to be completely unresponsive. Over the next 5 hours, Martin remained in hemorrhagic shock and had massive internal bleeding. Dr. Jenkins reported speaking with the family on multiple occasions, finally telling them that she did not believe he would survive and that it was only a matter of time. At midnight, Dr. Jenkins noted that her examination was consistent with brain death. Martin's family agreed to withdraw life support at 1:35 a.m., on January 6, 2006, and he was pronounced dead at 1:52 a.m. The first funeral was held on January 14, 2006, the day before his 15th birthday.

Cause of Death

Determination of the cause of Martin's death is complicated by the fact that each of the six physicians to examine the case reached different conclusions. Two autopsies were

performed. Dr. Charles Siebert, chief medical examiner in District 14 and located in Bay County, performed the first autopsy. Although section. 409.11, F.S., requires an autopsy to be performed by the medical examiner in the district where the death occurred, in this case Escambia County, the Bay County Sheriff's Office asked Dr. Siebert to take jurisdiction of the case. FDLE concurred in the request on the ground that since the incident had occurred in Bay County, performing the autopsy there would be more convenient for investigators. Occasionally medical examiners will concede jurisdiction to another in similar circumstances, and the evidence supports the conclusion that this happened in Martin's case.

Dr. Siebert concluded that Martin died as a result of sickling of his blood cells arising from his possession of sickle cell trait. He based his conclusion on his finding of sickling of cells in Martin's internal organs and massive internal bleeding consistent with damage caused to blood vessels by sickled cells. He testified in deposition that sickling deprives organs of necessary oxygen and tears blood vessels, resulting in massive hemorrhage and the build up of lactic acid, which in turn causes metabolic acidosis, ultimately leading to his death.

Dr. Siebert also noted bruising behind the ears, on the arms, and on the thighs, as well as lacerations inside Martin's lips. There was some speculation that the lacerations were caused by clamping Martin's mouth shut, but there was also evidence that they resulted when he was intubated, a procedure where a tube is passed through the nose to the lungs to help breathing. Dr. Siebert found no damage to the nasal passages, perhaps a significant finding, since ammonia is known to cause burns when it comes in contact with moist tissue.

Dr. Siebert also testified that the cause of sickling is oxygen deprivation. This can occur during exercise or for any reason, such as asphyxiation. Dr. Siebert supported his report with numerous articles discussing the risk of death arising from sickling due to the sickle cell trait. It appears that such a risk is extremely rare, but not unknown.

The second autopsy was performed by Dr. Vernard Adams at the request of State Attorney Mark Ober of the 13th judicial circuit. Mr. Ober became involved in the case at the request of Governor Bush after the state attorney for Bay County disqualified himself. See Executive Orders 06-36 and 06-37. Dr. Michael Baden, a claimants' expert, was present at the second autopsy, along with Dr. Siebert, the claimants' attorneys, and others.

Dr. Adams confirmed the physical findings of Dr. Siebert's autopsy, especially the bruising behind the ears, on the arms, and on the thighs. He also noted "prominent ischemic changes" in the brain and "striking sickling with stacking" in the lungs, liver, kidneys, and spleen. He noted sickling in the brain and other organs. Dr. Adams concluded that "neurological examination was consistent with brain death." He attributed the mechanism of death to suffocation due to "occlusion of the mouth and inhalation of ammonia." As to the effect of sickling, he stated, "I have no opinion as to whether the sickling at that time produced any tissue damage above and beyond that produced by suffocation." It thus appears that Dr. Adams attributes the substantial sickling in Martin's body to result from suffocation rather than some other cause.

Apparently not satisfied with Dr. Adams' opinion, Mr. Ober submitted the case to three other physicians for review, Drs. Thomas Andrews, John Downs, and Martin Steinberg. These three experts reviewed only medical and autopsy records. Dr. Andrews concluded that Martin developed sickling as a result of strain in the exercise yard before his collapse, perhaps influenced by dehydration. Death was caused, however, by a combination of factors, inappropriate use of ammonia capsules, "intermittent hypoxia," and the blows he suffered. Dr. Andrews wrote that death came from "the combination of these factors rather than any single one alone."

Dr. Downs, on the other hand, concluded, "It is my opinion that airway occlusion led to severe arterial hypoxemia, sickling and irreversible brain damage." Although he found

that sickling played a role, he said, "I believe that the majority of the brain injury was secondary to asphyxiation that occurred at the boot camp."

Like Dr. Andrews, Dr. Steinberg attributed Martin's death "to the unfortunate confluence of multiple factors. I believe that he likely had exercise-induced rhabdomyolysis[2] that occurred spontaneously. Initial laboratory studies suggest he might have been dehydrated during exercise. Rhabdomyolysis is more likely to be fatal in individuals with [sickle cell trait]. The officers responsible for his training did not make a distinction between malingering and a potentially fatal pathophysiological process and the attendant medical personnel did little to help this differentiation. This lead [sic] to physical restraint and the repetitive administration of ammonia that appeared to be associated with occlusion of the upper airway. This was likely to cause additional hypoxia that contributed to rhabdomyolysis and the irreversible events culminating in death."

Dr. Baden expressed yet another opinion. He testified at the Special Masters' hearing that death resulted from suffocation brought on by ammonia inhalation in combination with the clamping shut of Martin's mouth and the "manhandling" he received from officers. Under questioning, Dr. Baden testified that the blows Martin received did not contribute to his death. The manhandling he referred to was the claim that officers knelt on his back. During our review of the video, we could not see a single time when an officer knelt on Martin's back. This does not entirely rule out the possibility that an officer knelt momentarily on Martin's back, for he is not visible all the time he is on the ground. However, if that occurred, it did not last more than a few seconds, and we do not believe it occurred at all, given how the straight-armbar takedown[3] is carried out and an individual is then secured on the ground.

Given these medical opinions and the video, we find there is competent and substantial evidence to conclude that Martin's death occurred from the following sequence of events: Martin began suffering some distress during the run, probably as a result of sickling of his cells or rhabdomyolysis

due to mild exercise-induced oxygen deprivation. Had he been left alone, however, he would have recovered. The inappropriate administration of ammonia lasted at least continuously for 3 minutes and possibly for 4 minutes, during a time when his mouth was clamped shut and the capsule held directly under his nose so that he had no option but to breathe ammonia-laden air. This deprived him of oxygen for at least 3 minutes, causing his cells to sickle, if they had not already begun to do so, leading to an irreversible cascade of events that involved massive bleeding, organ failure and, ultimately, brain death. We further find that there is competent and substantial evidence that but for the prolonged administration of ammonia, Martin would not have died. Therefore, in conclusion, we find that Martin died primarily as a result of suffocation arising from forced administration of ammonia.

This conclusion does not end the inquiry into the immediate cause of death, however. There is also the role played by Nurse Schmidt to consider. Dr. Shairi Turner, DJJ's medical director, testified that ammonia capsules should not be held under the nose, but rather should be waved there only for a moment. She testified that the individual's mouth should not be held shut. She testified that any other method of application was inappropriate, and that these capsules were intended only for first aid use when someone has fainted.

Therefore, we also find that multiple failures by the nurse substantially contributed to Martin's death. First, she failed to train officers in the proper use of ammonia capsules. If they had been properly trained, they would not have administered ammonia as they did. As a medical professional, she knew or should have known how to properly administer ammonia capsules. Second, she failed to intervene when these capsules were improperly used by the officers. The nurse was there throughout this event and saw the officers' actions, yet she did nothing. In fact, a argument could be made that the officers were relying on her medical expertise that what they were doing was medically safe. Third, she failed to intervene when she knew or should have known that Martin was suffering acute distress, as he clearly was, as demonstrated on the video before the final

and fatal administration of ammonia. Had the nurse acted appropriately, it is likely that Martin would not have died.

THE BOOT CAMP'S USE OF AMMONIA FOR PAIN COMPLIANCE:

Several of the boot camp officers gave sworn testimony that it is a common practice to use ammonia capsules to force offenders to comply; particularly for offenders that try to get out of running laps by malingering.

- "it's a common practice when offenders act as if they can't breathe or going to pass out to pop an ammonia cap and they kind of decide that they would rather go ahead and do what they got to do." Sworn testimony of Drill Instructor Enfinger, 1/5/06.

- "every intake we have offenders that {try} to fake that they've passed out or can't run any, that's one of the techniques that we use is the capsule…" Testimony of Sgt. Patrick Garrett, 1/5/06.

- The use of the ammonia cap "… it's something we do on a regular basis." Sworn statement by Drill Instructor Adam Rogers, 1/9/06.

- "Normally the ammonia capsule is applied to the offenders by covering the mouth and then an ammonia capsule is placed under the nose of the offender so that he can breathe it in.… The purpose of covering the mouth is … that in the past we have had kids that hold their breath or close their mouth and don't inhale the ammonia and we've found that by covering their mouth that forces them to breathe through the nose and inhale the ammonia." Sworn statement of Lt. Cmdr. Helms, 1/18/06.

The Department of Juvenile Justice has no policy on the use of ammonia. In fact, the Department's Quality Assurance Standards for Boot Camps and Drill Academies does not list ammonia or smelling salts as something that must be included in the first aid kit; though the standard does not prohibit the use of same. Quality Assurance Standard 10.07. Dr. Shairi Turner, the Department's Chief Medical Director, testified that, "if you have to cover someone's

mouth to make sure they are getting ammonia then you should not be using ammonia." (Deposition of Dr. Shairi Turner, taken as part of State Attorney Ober's investigation; 6/29/06) Dr. Turner also testified that it appeared from the video tape that 911 should have been called 15 minutes before it was, and that all activity should have stopped at that point.

The use of ammonia is not addressed in either of the use of force policies authorized by the Department. The Protective Action Response (PAR) Policy (FDJJ – 1508-03) requires responses to be commensurate with the youth's level of resistance according the PAR Escalation Matrix. The PAR Escalation Matrix does not address the use of ammonia or any other chemical restraint. The PAR Policy in section III. O., provides that when law enforcement operated facilities partner with the Department, the officers are authorized to use Criminal Justice Standards and Training Commission (CJSTC) standards, and the sheriff shall determine the appropriate physical intervention responses. The Bay County Sheriff's Office Use of Force Policy states that "depending on the level of resistance offered, the officer may use techniques that may rise to a level of physical force that is intended to influence behavior through pain compliance in order to establish control," and states that force shall never be used as punishment. The use of ammonia was not addressed in the Bay County Sheriff's Office Use of Force Policy in effect at the time of the incident. However, the day after Martin's death, Bay County Sheriff McKeithen issued a memo prohibiting the use of ammonia capsules for "any purpose other than emergency situations such as attempting to revive a person who has obviously passed out. Even this will not be done for a prolonged period of time." An addendum to the memo, dated the same day, required that "ammonia capsules will only be administered by licensed medical personnel or by a drill instructor who has completed ample training in such procedures."

We find that there is competent, substantial evidence showing that ammonia capsules were used by officers at the Bay County Boot Camp in order to control offenders by use of pain compliance, in contravention of any policy of either

the Bay County Sheriff's Office or the Department of Juvenile Justice.

The expert testimony of William Gaut, a 24-year veteran of the Birmingham Police Department and former Detective Sergeant of the Homicide Division opined that the force used against Martin was unlawful, unreasonable, and excessive, and that the officers acted with conscious disregard for his rights and safety.

After conducting a full investigation, State Attorney Mark Ober charged the nurse and seven of the boot camp officers with the crime of aggravated manslaughter of a child, which is a first degree felony, punishable by up to 30 years in the Florida State Prison. The criminal case is still pending.

We find that there is competent and substantial evidence that the actions of the officers and the nurse employed by the Bay County Sheriff's Office were clearly negligent, and according to the testimony of the claimant's own expert were committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Given the finding that employees of the Bay County Sheriff were responsible for the death of Martin, the question remains whether the Department of Juvenile Justice knew or should have known about the manner in which ammonia was administered at the boot camp.

Pursuant to the contract between the Department of Juvenile Justice and the Bay County Sheriff's Office to operate a boot camp program that emphasizes paramilitary training, and §985.412, F.S. (which was transferred to §985.632, F.S., by 2006-120, L.O.F.), the Department is required to evaluate and monitor the program. While the record is devoid of any evidence showing that any employee of the Department witnessed any inappropriate use of force or administration of ammonia at the boot camp as part of any quality assurance review or audit, we find that it is reasonably foreseeable that the Department's failure to adequately investigate, evaluate, or monitor the Bay County Boot Camp resulted in a pattern

or practice of ammonia being administered for pain compliance, and that ammonia was administered by holding an offender's mouth shut. This finding is based on the following information which was in the Department's control:

- Between 2002 and 2006, the Department's Central Communication Center (24-hour incident reporting hotline) received 30 calls regarding the Bay County Boot Camp. Of those, 11 related to use of force allegations. Pursuant to policy, the allegations were referred to the Bay County Boot Camp staff, who investigated the allegations against their own officers and responded that all 11 force-related incidents were unsubstantiated. In one allegation an officer was disciplined for violating policies regarding the provision of medical assistance to youth.

- In July of 2002, the Department's Inspector General investigated one force-related incident called into the Central Communication Center by a Bay County Boot Camp staff alleging that another staff member grabbed a youth by the collar and pinned him against the wall causing the youth to strike his head against the wall. The Department's Inspector General substantiated the use of unnecessary force and the staff member received disciplinary action.

- Between 2003 and 2006, 174 Use of Force reports were made by officers at the Bay County Boot Camp and transmitted to the Department. While only one of these reports involves the administration of ammonia during intake, numerous reports involved the use of pressure points on intake day during the physical assessment, notwithstanding the fact that the use of pressure points had been prohibited by the Department Secretary Schembri in a Memo dated June 21, 2004. The reason for the prohibition of the use of pressure points provided that, "Too many youth have been injured in incidents with these techniques…. Experience has shown us that it is too easy to injure a young person when applying these holds. Physical restraint should be applied only to

prevent a youth from hurting himself or others, and to prevent property damage or escape."

- 118 of the 174 PAR reports described uses of force that were arguably excessive. An enormous number involved a blow or pressure point administered when the child was only verbally resistant, or even simply making faces or "breathing aggressively." Confronted with one such report at the hearing, Mr. Tallon,[4] the regional director for residential services at the time of the incident, admitted that applying a pressure point for only verbal resistance was excessive. He testified that he read most of these reports, and a subordinate reviewed those he did not see. Therefore, DJJ was on notice that excessive force was being used at the boot camp.

- Mr. Tallon also testified that, at least while he was regional director with authority over the boot camp, a DJJ representative was required to be present during the intake process, which would have included the physical assessment. Given the fact that improper use of ammonia as a pain compliance tool was a pattern and practice of the boot camp and given that most such applications were likely to have occurred during the intake physical assessment when children were most likely to be out of shape and resistant to exercise, the DJJ representative did see, or should have seen, wrongful applications of ammonia.

- Charles Chervanik, the Department's Assistant Secretary for Residential Facilities, received an email from the Supervisor of Program Support saying that the boot camps would not comply with the Secretary's memo of June 21, 2004, prohibiting the use of pressure points. Assistant Secretary Chervanik replied that the Secretary's directive does not apply to the boot camp's CJSTC trained and certified staff.

- The Department's Use of Force reports continued to include a box to check if pressure points were used, in spite of the Secretary's memo to discontinue the use of pressure points.

Richard Davidson, the current Assistant Secretary of the Department testified at the Special Masters' hearing that, "when a juvenile is committed to the Department of Juvenile Justice, it is the Department's responsibility to provide the care, custody, control, and treatment of that juvenile."

LEGAL PROCEEDINGS:

Martin's parents, Robert Anderson and Gina Jones, as co-personal representatives of the Estate of Martin Lee Anderson, and as the survivors of Martin Lee Anderson, initially filed suit in the Second Judicial Circuit in and for Leon County Florida on July 12, 2006. The initial complaint named the Department of Juvenile Justice and the Bay County Sheriff's Office, and alleged 10 counts against both named defendants, including several violations of 42 U.S.C. section 1983. The case was subsequently removed to the United States District Court for the Northern District of Florida (Case No. 4:06-CV-00374-RH/WCS).

Pursuant to Order Dismissing the First Complaint in Part issued by Judge Hinkle on October 17, 2006, based on Motions to Dismiss made by the Department and the Sheriff, the ten counts were disposed as follows:

1. Negligence per se against the Department – dismissed.

2. Vicarious liability against the Department – not dismissed.

3. Direct negligence against the Department – not dismissed.

4. Common law negligence against the Sheriff – not dismissed.

5. 42 U.S.C. 1983 violation against the Department for a general violation of Martin Lee Anderson's constitutional rights – dismissed.

6. 42 U.S.C. 1983 violation against the Sheriff for deprivation of medical care – not dismissed.

7. 42 U.S.C. 1983 violation against the Department for deprivation of medical care – dismissed.

8. 42 U.S.C. 1983 violation against the Department for excessive use of force and deprivation of due process – dismissed.

9. Conspiracy between the Department and the Sheriff – dismissed.

10. Breach of contract – dismissed.

The claimants then filed a Second Amended Complaint, which named the Department, the Sheriff, and the seven individual officers as defendants. The nurse was not named. The Second Amended Complaint included 15 counts against the named defendants. The defendants answered, filed affirmative defenses, and Motions to Dismiss. The last Order issued by the court set the discovery deadline for May 14, 2007, the deadline to conclude mediation for June 11, 2007, and continued the civil trial until after the criminal trial concluded.

LEGISLATIVE PROCEEDINGS: Before the discovery deadline in the civil case, Governor Charlie Crist wrote to Senate President Ken Pruitt and Speaker of the House of Representatives Marco Rubio informing them that the Department reached a settlement with Martin's parents, and that he directed the Department to agree to support a claim bill in the Legislature in the amount of $5 million. Governor Crist asked that legislative rules be waived in order to allow for the late filing of such a claim bill.

The settlement with the Department provides that for the consideration of $200,000, Robert Anderson and Gina Jones release all claims against the Department, and in return the Department will support a claim bill in the amount of $4.8 million. A Motion for Voluntary Dismissal of the pending case has been filed, but not ruled upon. The Department has paid the $200,000. The Special Masters asked for, but did not receive, a closing statement indicating how the $200,000 was distributed.

Shortly thereafter, Martin's parents also entered into a settlement agreement with the Bay County Sheriff, the seven named officers, and the nurse. The settlement agreement provides that in consideration of $2.425 million paid to Robert Anderson and Gina Jones, they will release and discharge the Bay County Sheriff, the seven named officers, and the nurse from all liability. Based on the settlement, the Bay County Sheriff, the seven named officers, and the nurse filed a Joint Motion for Dismissal, which Motion has not yet been ruled upon.

The source of payment for the $2.425 million was the Florida Sheriff's Self-Insurance Fund. A check in the amount of $2.425 million has been delivered to the claimants. The Special Masters asked for, but did not receive, a closing statement indicating how the $2.425 million was distributed.

RIPENESS UNDER HOUSE AND SENATE RULES:

Senate Rule 4.81 and Rule 5.6 of the Rules of the House of Representatives provide that the hearing and consideration of a claim bill shall be held in abeyance until all administrative and judicial remedies have been exhausted, except that the hearing and consideration of a claim that is still within the judicial or administrative system may proceed when the parties have executed a written settlement agreement. As settlement agreements have been executed with all of the defendants named in the civil law suits, we find that the claim need not be held in abeyance, as long as the judge dismisses the civil case in accordance with the Motions to Dismiss.

CLAIMANT'S POSITION:

Before the hearing, the claimants listed a number of legal theories of liability.[5] Many of them were not raised in their lawsuit against the department, Anderson v. Department of Juvenile Justice, U.S. District Court Northern District of Florida, case no. 4:06cv374-RH. Only the claims brought in that lawsuit pursuant to the Second Amended Complaint which were not dismissed were considered in this proceeding:

1. DJJ was vicariously liable for the actions of Bay County Sheriff's deputies toward Martin Lee Anderson for actions taken in the course and scope of their employment that led to his death.

2. DJJ was negligent in failing to monitor, supervise, and control the Bay County Sheriff's Office in the operation of the boot camp.

3. DJJ breached a duty of care it owned toward Martin Lee Anderson, leading to his death.[6]

RESPONDENT'S POSITION: The respondent Department did not oppose the claims.

CONCLUSIONS OF LAW:

Duty of Care

1) *Vicarious liability*. The claimants contend that the Department was vicariously liable for the actions of the deputies, citing Stoll v. Noel.[7] Under Stoll, a contractor of a state agency is an agent if the state retains control through the contract to direct its activities. The case involved the question whether the defendant contractor was entitled to sovereign immunity under s. 768.28, F.S., not whether the state agency was vicariously liable for the acts of the contractor. However, the reasoning of the case could apply to this case by analogy.[8]

The existence of a contract alone does not establish an agency relationship sufficient to impart vicarious liability to the principal.[9] The control exercised over the thing that caused the injury must be extensive.[10] Furthermore, substantial deviations from the state's instructions deprive the contractor of agency status.[11]

The claimants asserted that various parts of the contract between the Department and the Bay County Sheriff's Office were evidence of the Department's degree of control over the Sheriff as to the use of force.

However, it is not necessary to determine whether the Bay County Sheriff's Office acted as the Department's agent for

purposes of vicarious liability. First, the claimants alleged in the Second Amended Complaint that the actions of the deputies were "unauthorized," violent, and brutal. This is an allegation of such substantial deviation from the use of force policies either of the Department or the Bay County Sheriff's Office such that it would deprive the Bay County Sheriff's Office of agency status, if it existed. In addition, since we find that ammonia usage as practiced at the boot camp was for pain compliance rather than medical care, such use necessarily is a substantial deviation from both the Department's and the Bay County Sheriff's Office use of force policies.

Moreover, the deputies' and the nurse's actions were committed "in a manner exhibiting wanton and willful disregard of human rights, safety, or property." Section 768.28(9)(a), F.S., provides that the state or its agencies are not liable in such circumstances.[12]

Thus, the claimants' vicarious liability theory is untenable.

2) *The failure to monitor, supervise, and control the Bay County Sheriff's Office*. The legal basis of this case is not well explained by the claimants. It may arise from their contention, expressed in their court papers, that the Department had a duty of care arising under the law and its rules and policies to monitor, supervise, and control BSO.[13] However, the claimants did not identify any such law, rules, or policies. This does not end the matter, however. Monitoring and supervision will be discussed below in the context of the Department's general duty of care.

3) *General duty of care*. The claimants assert that the Department had a nondelegable duty of care toward Martin Lee Anderson. Under such a theory, the fact that the Department relied on a contractor to carry out its responsibilities did not absolve it of vicarious liability for the actions of the Bay County Sheriff's Office.[14] Unfortunately, the claimants did not identify the specific statutes, rules, and policies (and specific parts thereof) that they contend gave rise to any nondelegable duty.

Moreover, apart from the fact that the willful, wanton nature of the deputies' and nurse's actions preclude a finding of state liability, the case law indicates that the Department may not have a nondelegable duty of care concerning children committed to its custody.[15]

However, the Department does have a *general* duty of care toward juveniles committed to its custody arising from the fact of their commitment.[16] This general duty of custodial care imposes liability only for reasonably foreseeable harm, such as harm flowing from placement in a "zone of risk."[17]

Consequently, in this case, the Department had a duty of care to ensure that the placement of Martin Lee Anderson at the boot camp did not put him in a zone of risk. Put another way, the Department had a duty of care to ensure that Mr. Anderson was in a reasonably safe placement.[18] Such a duty of care does not expose the Department to strict or vicarious liability for the deputies' actions. Rather, the Department's custodial liability turns on whether it knew or should reasonably have known that the boot camp was unsafe.[19]

Based on the 174 PAR reports and the fact that a DJJ observer at intake should have seen inappropriate ammonia use, we find that the Department knew or reasonably should have known that deputies were inappropriately using force against juveniles in the boot camp. Such notice triggered a duty to investigate the use of force at the boot camp, which reasonably should have disclosed the fact that ammonia capsules were being used, not for medical purposes, but as pain compliance tools to compel juveniles to complete mandatory exercises.

Breach of Any Duty of Care
Based on the foregoing, we conclude that the Department breached its duty of care to ensure that Martin Lee Anderson was given a reasonably safe placement.

Proximate Cause
In a wrongful death case, the alleged negligence must be the legal cause of death.[20] Therefore, any negligence related to

the blows administered to Martin Lee Anderson does not support recovery, since the blows did not cause his death. The primary cause of death was suffocation by Bay County Sheriff's Office deputies arising from prolonged and inappropriate administration of ammonia, possibly aggravating (or even in conjunction with) a pre-existing medical condition, Mr. Anderson's sickle cell trait.[21] A secondary cause of death was the nurse's failing to train deputies in the administration of ammonia, allowing ammonia capsules to be improperly administered to Martin Lee Anderson, and failing to intervene when he was in obvious physical distress. As a medical professional, the nurse reasonably should have known how to appropriately administer ammonia capsules and should have intervened when she saw them improperly used. See statement of Dr. Shairi Turner at pp.51-60.

The Department's failure to appropriately monitor the boot camp after notice of potentially dangerous practices there, and its failure to ensure a reasonably safe placement were contributing causes of death.

DAMAGES:

The total amount due to the claimants based on settlements with DJJ and BSO is $7.245 million. The settlement with the Sheriff calls for a payment of $2.245 million; the settlement with DJJ provides for $5 million. The total amount is not inconsistent with wrongful death and personal injury verdicts returned by Florida juries. So, it is not unreasonable to assume that a jury verdict could have ranged from $8 million to $10 million.

Section 768.81(3), F.S., requires damages to be apportioned on the basis "of such party's percentage of fault." The law does not permit joint and several liability.

Because the manner used to administer the fatal ammonia dosages resulted from a policy and practice of the boot camp and because the nurse had an obligation to prevent such improper practice (but in fact abetted it), we find that BSO, the individual deputies and the nurse were at least 75 percent at fault. We find that DJJ was at most 25 percent at fault.

Assuming a damages award of $10 million, DJJ should be liable for no more than $2.5 million. DJJ has already paid $200,000, pursuant to the limits of s. 768.28, F.S. Therefore, $2.3 million in damages attributable to DJJ's negligence remains outstanding.

MISCELLANEOUS ISSUES:

Ms. Jones is married to Carl Telford Jones who, at the time of the incident, was unemployed. Mr. Jones has a 1996 conviction for selling cocaine within 1000 feet of a school, for which he was sentenced to 5 years in prison. He was most recently arrested last month and charged with possession of a controlled substance without a prescription. Ms. Jones' attorney stated that none of the amount awarded by this bill would go to Mr. Jones, though the bill does not specifically prohibit same.

ATTORNEYS FEES:

Section 768.28(8), F.S., limits attorneys' fees to 25 percent of any sum received in judgment or settlement. The claimants' attorneys stated that they will receive no more than 25 percent of any amount awarded. Attorneys for the claimants have submitted an affidavit that the claimants have incurred and are obligated to pay 25 percent of any recovery as attorney's fees and costs. The affidavit also specifies that 10 percent of the 25 percent attorney's fee will be paid to the Pittman Law Group, as a lobbying fee. The Special Masters requested billing reports or some evidence of the amount of time spent on this case; no such evidence was presented.

RECOMMENDATIONS: We recommend that an amendment be prepared to reduce the amount of payment to Claimants from $5 million to $2.3 million, in accordance with DJJ's attributable negligence.

Based on the foregoing, we recommend that SB 2968 (2007) be reported FAVORABLY, as amended.

Respectfully submitted,

Jason Vail
Senate Special Master

Stephanie Birtman
House Special Master

cc: Senator Tony Hill
Faye Blanton, Secretary of the Senate
Counsel of Record

ENDNOTES

[1] The claimants submitted two versions of the video: the version as released, which begins before Martin's group begins its exercises, and the "NASA enhanced" version. We studied both versions repeatedly. The claimants showed portions of the NASA version at the hearing.

[2] Rhabdomyolysis is the release of potentially toxic substances into the blood often as the result of damage to muscles.

[3] FDLE provided written descriptions of the approved methods for carrying out the uses of force applied against Martin.

[4] Note that after the Special Master hearing, John Tallon was fired as the regional residential services administrator of the Department and acting superintendent of Dozier School for Boys in Marianna, in the wake of allegations that a guard used inappropriate force on an 18-year old youth.

[5] General negligence, negligent hiring, negligent retention, negligent supervision, negligent authorization of the use of chemicals, negligent training on the use of ammonia, conspiracy, breach of duty of care, vicarious liability.

[6] At the hearing, the claimants did not address general negligence, negligent retention, negligent supervision, negligent authorization of the use of chemicals, or negligent training.

[7] 694 So.2d 701 (Fla. 1997).

[8] See e.g., Folwell v. Bernard, 477 So.2d 1060 (Fla. 2d DCA 1985) (constitution and canons of church diocese were in nature of contract with parish; but these documents did not give diocese sufficient control over operation of parish).

[9] Vasquez v. Board of Regents, 548 So.2d 251, 254 (Fla. 2d DCA 1989).

[10] Laborers' International Union of North America v. Rayburn Crane Service Inc., 559 So.2d 1219, 1223 (Fla. 2d DCA 1990); Folwell v. Bernard, 477 So.2d 1060, 1063 (2d DCA 1985).

[11] Sierra v. Associated Marine Institutes Inc., 850 So.2d 582, 590 (Fla. 2d DCA 2003).

[12] Section 768.28, F.S., provides in relevant part that, "The state or its subdivisions shall not be liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of her or his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property."

[13] See *e.g.* Abril v. Department of Corrections, 884 So.2d 206,209 (Fla. 2d DCA 2004) (when a statute creates a clear duty of care, the violation of that duty can generate a viable cause of action); Pollock v. Florida Department of Highway Patrol, 882 So.2d 928, 936-937 (Fla. 2004 (internal policies and procedures do not create an independent duty of care unless they are adopted as standards of conduct).

[14] See M.S. v. Nova University, 881 So.2d 614 (4th DCA 2004); Carrasquillo v. Holiday Carpet Service Inc., 615 So.2d 862 (Fla. 3d DCA 1993).

[15] See Zink v. Department of Health and Rehabilitative Services, 496 So.2d 996 (Fla. 5th DCA 1986).

[16] Department of Health and Rehabilitative Services v. Whaley, 574 So.2d 100, 103-104 (Fla. 1991); Kaisner v. Kolb, 543 So.2d 732, 734 (Fla. 1989).

[17] Whaley at 104; Pollock, 882 So.2d at 935 (liability for placing detainees in a zone of risk); Smith v. Florida Power & Light Co., 857 So.2d 224, 229 (Fla. 2d DCA 2003) (foreseeability and the zone of risk define the scope of a defendant's duty).

[18] See *e.g.*, Florida Department of Health and Rehabilitative Services v. S.A.P., 835 So.2d 1091, 1100 (Fla. 2002) (allowing an action for negligent monitoring and supervision of a foster care placement to go forward).

[19] Zink, supra; Whaley, supra.

[20] McKinnon v. Pengree, 455 So.2d 1134, 1135 (Fla. 2d DCA 1984).

[21] The fact that Mr. Anderson's possession of the sickle cell trait may have contributed, in some way, to his death does not absolve either DJJ or BSO. See Hadley v. Terwilliger, 873 So.2d 378, 380 (Fla. 5th DCA 2004); Hart v. Stern, 824 So.2d 927, 930 (Fla. 5th DCA 2002).