



STORAGE NAME: h6515.CJC

DATE: 3/6/2017

March 6, 2017

SPECIAL MASTER'S FINAL REPORT

The Honorable Richard Corcoran
Speaker, The Florida House of Representatives
Suite 420, The Capitol
Tallahassee, Florida 32399-1300

Re: HB 6515 - Representative Jones
Relief of Wendy Smith and Dennis Darling, Sr. by the State of Florida

THIS IS AN UNCONTESTED CLAIM FOR \$1,800,000 PREDICATED ON A SETTLEMENT AGREEMENT ENTERED BETWEEN DENNIS DARLING SR., AND WENDY SMITH, PARENTS OF, DEVAUGHN DARLING, AND THE FLORIDA STATE UNIVERSITY, BASED ON DAMAGES SUSTAINED DUE TO THE ACTIONS OF COACHES AND TRAINERS DURING PRESEASON CONDITIONING DRILLS THAT RESULTED IN DEVAUGHN DARLING'S DEATH. THE UNIVERSITY HAS ALREADY PAID \$200,000 PURSUANT TO SECTION 768.28, F.S..

FINDING OF FACT:

On February 26, 2001, Devaughn Darling, a Florida State University (FSU) football player who had been diagnosed with sickle cell trait died during preseason conditioning drills. Darling, along with other members of the football team, had recently finished a rigorous 90 minute cardiovascular and agility drills involving three different 20 to 25 minute stations. Drills were performed by "lines" of five to six players each, with brief breaks between drills. Players were monitored by coaches and training staff during each drill. The final drill, known as "mat drills," required players to dive to the mats, roll left and right based on the coach's directions, followed by quick movement, left and right slides, and brief sprints. By the end of the drills,

players were extremely tired with vomiting during drills a common occurrence. Players were instructed on how to properly hydrate and were told to be well hydrated the night before drills. Although limited access to water was available during the drills, the brevity of the breaks combined with an atmosphere that discouraged any sign of weakness caused players to avoid water during the drills.

At some time between 7:05 a.m. and 7:10 a.m., Randy Oravetz, head trainer, observed Darling, the last person to complete the mat drills, running from the mats to an adjacent wall where he fell to his knees and rested his head against the wall. Oravetz and another trainer or player helped Darling back on to the mat. Darling's breathing was erratic, but he was conscious and coherent. Oravetz moved Darling to the training room to stabilize Darling's breathing and get him cooled off. He also moved Darling because the rest of the team needed the mat for another drill. The move to the training room took approximately 40 seconds to 1 minute. Once in the training room, Darling was placed on a training table, given sips of water, ice packs, and oxygen. At that time, Darling had a pulse, was breathing, and was coherent. However, after a minute or two, at approximately 7:13 a.m., Darling's eyes rolled back into his head, Oravetz immediately ordered his graduate assistant to call 911 and began CPR.

When the first FSU police officers arrived at approximately 7:18 a.m., Darling did not have a pulse and FSU training staff were performing CPR. At approximately 7:35 a.m., an FSU police officer arrived with an advanced external defibrillator (AED) that was immediately connected to Darling. After automatically evaluating his vital signs, the AED advised not to shock and recommended continued CPR. The AED again evaluated his vital signs at 7:38 a.m. and, again, advised not to shock and recommended continued CPR. At that time, emergency medical services arrived, continued emergency treatment, and transported Darling to Tallahassee Memorial Hospital where he was pronounced dead around 8:50 a.m.

An autopsy was conducted on Darling by the Medical Examiner in Tallahassee; it was reviewed by a cardiovascular pathologist at the Armed Forces Institute of Pathology. The pathology reports diagnosed Darlings death as sudden unexpected death and found no morphologic cause of death. The reports noted diffuse red cell sickling and commented that, "Although rare, sudden unexpected death has been associated with healthy athletic males with sickle cell trait. Sickle cell trait appears to lower the threshold for ventricular arrhythmias in patients exposed to exertional heat injury."

Although other players indicated that during drills Darling complained of chest pains and fatigue and was having problems standing and seeing, none of the players indicated

Darling informed the coaches or trainers about any of these issues. Additionally, some players indicated that Darling's complaints were consistent with those of other players during the course of mat drills. According to coaches and trainers, Darling did not report any physical problems before his collapse and none indicated that the level of fatigue and exhaustion Darling exhibited were inconsistent with other players and were out of the ordinary.

For reasons that are unclear, Darling was taking pseudoephedrine and acetaminophen, neither of which were reported to trainers or coaches. He was also taking Vioxx for a prior sprained ankle.

In July of 2000, as part of a required medical screening for student athletes at FSU, Darling tested positive for sickle cell trait. Head trainer Randy Oravetz and assistant trainer Marshall Walls, knew of Darlings diagnosis as a carrier of sickle cell trait. It was FSU's policy to have athletes diagnosed with sickle cell trait meet with the team physician to discuss precautions and warning signs associated with that condition. At the time of Darlings death, there were seven FSU football players with sickle cell trait and the NCAA guidelines at the time noted that no medical body suggested any restrictions on athletes with sickle cell trait and indicated that no restrictions or limitations should be placed on athletes with sickle cell traits. The NCAA guidelines recommended that all athletes should be counseled to avoid dehydration and to acclimatize and condition gradually.

LITIGATION HISTORY:

In August 2001, the Claimants, Dennis Darling, Sr., and Wendy Smith, Devaughn Darling's parents, notified FSU of their intent to sue, and in late 2001 they filed suit against FSU for negligence. The parties went to agreed-upon mediation in November 2003, which ultimately led to a court-approved, stipulated \$2 million settlement agreement entered on June 28, 2004. Under the terms of the settlement, the parents received \$200,000 with the remaining \$1.8 million to be collected upon passage of a claim bill.

CLAIMANT'S POSTION:

The Claimants allege the following: FSU owed a duty to its football players, including Devaughn Darling, to develop, plan and execute a conditioning program that was reasonably safe and would not endanger the lives of its players. FSU breached this duty by:

- a. Failing to provide the players, specifically Devaughn Darling, with proper access to water and other fluids during mat drills.
- b. Demanding that players continue with the drills while exhibiting physical distress.
- c. Failing to provide sufficient rest periods during these exercises.
- d. Failing to provide adequate medical and emergency

- personnel and medical equipment during mat drills.
- e. Failing to provide adequate supervisors during mat drills who should recognize when a player is in physical distress.
- f. Negligently organizing and executing the mat drills.
- g. Failing to timely call for emergency assistance.
- h. Failing to maintain an adequate emergency plan pursuant to NCAA guidelines.
- i. Failing to provide proper access to water and other fluids for players who have sickle cell trait, pursuant to NCAA guidelines.

As a result of FSU's negligent conduct, Darling was placed under unreasonable physical distress and died.

RESPONDENT'S POSITION:

FSU denies any negligent conduct, but supports passage of a claim bill.

CONCLUSION OF LAW:

To establish a claim of negligence, the Claimants must prove four elements by a preponderance of the evidence: (1) the existence of a duty on the part of the FSU to avoid injuring Darling; (2) a breach of that duty by the FSU; (3) proximate cause; and (4) injury or damage to Darling arising from the FSU's breach of the duty. Based on the statements, depositions, testimony, and other evidence, the Claimants have proven their claim of negligence by a preponderance of the evidence. Each element will be addressed in turn.

Duty

In Florida, "a legal duty will arise whenever a human endeavor creates a generalized and foreseeable risk of harming others."¹ It is clear that the operation of a collegiate football program entails activities that pose a foreseeable risk of harm to football players. As a result, football program coaches and staff are required to exercise prudent foresight to lessen the risk of injury or take sufficient precautions to protect players from the harm that the risk poses.² Accordingly, FSU had a duty to its football players, including Darling, to develop and execute a conditioning program that was reasonably safe with sufficient precautions taken to protect the players from the harm associated with the conditioning program.

¹ *Owens v. Publix Supermarkets, Inc.*, 802 So. 2d 315, 330 (Fla. 2001) (quoting *McCain v. Florida Power Corp.*, 593 So.2d 500, 503 (Fla.1992)).

² See, e.g., *Leahy v. Sch. Bd. of Hernando County*, 450 So.2d 883, 885 (Fla. 1st DCA 1984) (school board owed duty to properly supervise spring football practice as approved school activity in which school employees had authority to control behavior of students); *Kleinknecht v. Gettysburg Coll.*, 989 F.2d 1360, 1367 (3d Cir. 1993) (college had special relationship with lacrosse player sufficient to impose a duty of reasonable care on the college); *Beckett v. Clinton Prairie Sch. Corp.*, 504 N.E.2d 552, 553 (Ind.1987) (high school personnel have duty to exercise ordinary and reasonable care for safety of student athletes under their authority).

Breach

Breach of a duty occurs when an individual fails to exercise ordinary and reasonable care, according to the circumstances, in carrying out his or her duty to the injured party.³ The Claimants allege FSU breached its duty nine ways, each will be discussed in turn.

(a) Failing to provide the players, specifically Devaughn Darling, with proper access to water and other fluids during mat drills. Statements and depositions by players and staff regarding the availability of water was divided. Trainers indicated that water was available to players at water fountains, water stations, or by water bottles carried by trainers, but there were only brief breaks of between 30 seconds and 1 minute during and between stations where players had time to get water. An assistant trainer indicated, it was "frowned upon" if a player was being lazy and trying to get water as an excuse to avoid completing a drill. In addition to coaches and trainers, Bob Thomas, a reporter with the Florida Times Union who was present at the drills, indicated to police that water was available to players. One player, on the other hand, indicated that no water was provided. Other players, however, stated that although there were water fountains nearby, they were discouraged from getting water during drills. No player indicated that any water, other than from water fountains, was nearby. If they tried to get water from the fountains during a break between stations, the coaches would push them along. As stated by Darling's twin brother, also an FSU football player, it was an unwritten rule that players were not allowed to get water. Instead, players were instructed to stay hydrated the night before drills; but as stated by at least one player, drinking too much water just before or during drills could lead to vomiting. Despite the contradictory statements and testimony between the staff and players, the Claimants have established that only minimal access water was "available." The coaching staff created an environment that in effect prevented players from getting water except in rare and limited situations. In light of the strenuous nature of the drills, FSU's failure to make water readily available and to encourage proper hydration during the drills was unreasonable.

(b) Demanding that players continue with the drills while exhibiting physical distress. Conditioning drills are designed to push players and acclimatize them to the physical and mental challenges faced during a real game. Frequently, this requires coaches to push players beyond their normal comfort level, to push through pain and fatigue, to finish drills. The drive to complete the drill must, however, be balanced against the well-being of the players. While the line between pushing to achieve a legitimate goal and pushing to a point where a player's well-being is in jeopardy is not always clear, the evidence

³ See *Brightwell v. Beem*, 90 So. 2d 320, 322 (Fla. 1956).

establishes that FSU crossed the line and unreasonably jeopardized the safety of its players.

As one FSU player put it, the motto during the drills was "finish the drill." There was pressure from coaches and players to finish each drill no matter how a player felt. Another player stated that the point of the drills was to push players past their breaking point and that this was especially true of younger players, such as Darling. Part of this regime was that players would have to regularly repeat drills if they were not completed to a coach's satisfaction. This meant that a player who was already fatigued and unable to satisfactorily complete a drill would be required to repeat the drill. Although Head Trainer Randy Oravetz testified that a player's performance during conditioning drills did not impact their future playing time, Oravetz assistant, Walls, as well as a number of players, were unanimous that players were graded on their performance during drills and that failure to perform well would impact their playing time. Consequently, any sign of weakness, such as briefly stepping out of line because a player felt dizzy, could negatively impact that player's prospects for playing time.

The result of the pressure created by coaches to "finish the drill," to push past the breaking point, and to perform well enough to get playing time, led coaches to unreasonably disregard the players' safety and well-being by pushing players to continue drills while they exhibited signs of physical distress.

(c) Failing to provide sufficient rest periods during these exercises. Any rest periods the players may have had would have come between stations or while at a station in between groups completing drills at that station. The testimony regarding the length of breaks players got during these periods is inconsistent. Randy Oravetz stated that players had about four minutes of rest between each station. However, players indicated that there were no breaks between stations as players were supposed to be running or jogging between stations. Others indicated that although they would get short breaks while other groups completed drills, the length of the break would depend on whether the group the player was in got sent back to redo the drill. Bob Thomas with the Florida Times Union indicated that players would get short breaks of between 60 and 90 seconds between each drill. Although the divergence in these statements alone make it difficult to determine the true amount of rest available to players, these statements, combined with the other statements made by trainers and players in sections (a) and (b) above regarding the access to waters and the atmosphere and pace of the drills lead to the reasonable inference that FSU failed to provide sufficient rest periods during the drills.

(d) Failing to provide adequate medical and emergency personnel and medical equipment during mat drills. Statements

and depositions by trainers and players establish that players were constantly monitored during conditioning drills by at least one coach and one trainer. Every trainer was CPR certified and knew first-responder procedures. There is no evidence that medical personnel or medical equipment, such as an AED, were provided during drills. However, the Claimants have not established that this lack of medical personnel or medical equipment is an example of FSU's failure to exercise ordinary and reasonable care under the circumstances. Based on their experiences running conditioning drills and their knowledge of the risks associated with those drills, the coaches and trainers had no reason to believe additional medical or emergency personnel or equipment were necessary. While the conditioning drills were designed to push players to the edge of their physical ability, regularly caused players to vomit, and occasionally led to players passing out, feeling dizzy, and having chest pains, the Claimants have not shown that FSU coaches and trainers should have reasonably expected a player to suffer an emergency that would require immediate medical attention beyond their capabilities or cardiac arrest, which would necessitate immediate access to an AED.

Even assuming, arguendo, FSU unreasonably failed to provide medical personnel or medical equipment, such a failure was not the proximate cause of Darling's death. (See Causation discussion below).

(e) Failing to provide adequate supervisors during mat drills who should recognize when a player is in physical distress.

Statements and depositions by trainers and players indicate that players were constantly monitored during conditioning drills and at each of the three stations there was at least one coach and one trainer. Head Trainer, Randy Oravetz, testified that he has never had a problem with intervening during mat drills to remove players from the drill when they show signs of physical distress, such as vomiting, passing out, chest pain, and dizziness. If a player was removed, he would be immediately evaluated by training staff. Assistant Trainer, Marshall Walls, likewise testified that it was the trainer's decision to remove a player from drills and that trainers would not push a player to continue a drill but would leave it up to the player to make the decision to continue. In fact, a week before Darling's death, during a running station, Darling had difficulty completing the drill and went down on one knee. Walls attended to Darling, and Darling indicated he was having a little trouble breathing. Although Darling wanted to get back up and finish the drill, Walls had him wait and catch his breath before returning and finishing the drill. Later that morning, Walls asked Darling what happened, Darling responded that he was just fatigued. Walls then asked if there was anything they needed to do, Darling replied, "no, I'll be fine." At least one player indicated that although coaches would question a player's work ethic if he went to the training staff, players could, and did, go to trainers

during drills or when ill and the trainer would tell coaches which drills and activities the player could participate in. In addition to trainers and players, Bob Thomas, the Florida Times Union Reporter present during drills, also indicated that over his two days of watching drills, he saw trainers immediately attend to any injury and fatigue issues.

In sum, the statements and testimony indicate that FSU provided adequate supervision during mat drills and that the trainers and staff who were supervising the drills recognized and intervened when necessary for a player in distress.

(f) Negligently organizing and executing the mat drills. Beyond the evidence provided by the Claimants to establish the eight other specific ways FSU breached its duty, the Claimants failed to provide any specific evidence to establish this non-specific allegation.

(g) Failing to timely call for emergency assistance. Head Trainer Randy Oravetz testified that between 7:05 a.m. and 7:10 a.m., he observed Darling running from the mats to an adjacent wall where he fell to his knees and rested his head against the wall. Oravetz and another trainer or player helped Darling back on to the mat. Darling's breathing was erratic, but he was conscious and coherent. Oravetz moved Darling to the training room, which took approximately 40 seconds to 1 minute. When they got the training room, Darling had a pulse, was breathing, and was coherent. After a minute or two, at 7:13 a.m., Darling's eyes rolled back into his head and Oravetz immediately ordered his assistant to call 911 and began CPR. The first FSU police officers arrived at approximately 7:18 a.m., and at approximately 7:35 a.m., an FSU police officer arrived with an advanced external defibrillator (AED) that was immediately connected to Darling. The AED twice advised not to shock and to continue CPR. At approximately 7:38 a.m., emergency medical services arrived, continued emergency treatment, and transported Darling to Tallahassee Memorial Hospital, where he was pronounced dead around 8:50 a.m.

FSU's emergency management plan includes "respiratory arrest or any irregularity in breathing" among the conditions for which 911 must be called. Given the strenuous nature of the drills, it was not uncommon for players to be near the point of exhaustion, breathing rapidly, and struggling at the end of drills similar to Darling. Additionally, although Darling's teammates almost unanimously state that Darling told them he could not see, was tired, and was having chest pains, there is no evidence indicating that Darling or the other players ever conveyed this information to the coaches or the trainers. Consequently, based on Oravetz's experience with players in similar states of exhaustion and his lack of knowledge of Darling's specific problems, he made a reasonable decision not to initiate a 911 call immediately when he noticed Darling's

breathing issues. Even if Oravetz's decision not to call 911 immediately was unreasonable and therefore a breach of the duty of care, such a delay was not the proximate cause of Darling's death. (See Causation discussion below).

(h) Failing to maintain an adequate emergency plan pursuant to NCAA guidelines. The evidence clearly established that FSU maintained an emergency plan that included procedures for the emergency care of an athlete in respiratory or cardiac arrest. The Claimants did not present any evidence, either through expert testimony or any other type of evidence, to prove that the emergency plan was not adequate pursuant to NCAA guidelines.

(i) Failing to provide proper access to water and other fluids for players who have sickle cell trait, pursuant to NCAA guidelines. Contrary to the Claimants allegation, the NCAA guidelines in place during 2001 did not provide specific hydration guidelines for players with sickle cell trait. Instead, the guidelines recommended that *all* athletes should be counseled to avoid dehydration. However, as explained in (a) above, the Claimants have established that FSU failed to provide proper access to water to all the players during drills, including those players with sickle cell trait.

Causation

Proximate cause is concerned with "whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred."⁴ A finding of proximate cause consists of four components: was the injury a reasonably foreseeable consequence of the defendant's negligence; was the injury a natural and probable consequence of the defendant's negligence; was the defendant's negligence a substantial factor in producing the injury, and; was there a natural, direct, and continuous sequence between the negligent act and the injury that it can reasonably be said that *but for* the act the injury would not have occurred.⁵

The evidence shows that FSU breached its duty of care by failing to provide players with proper access to water, by failing to provide sufficient rest periods, and by creating an environment in which players felt compelled to complete drills regardless of the physical state. The evidence also proves that these actions foreseeably and substantially caused Darling's death. Although the death of a player may not have been a foreseeable consequence of FSU's conduct, FSU will still be liable "if it could have foreseen that *some* injury would likely result in *some* manner, similar to that which actually happened,

⁴ *Goldberg v. Florida Power & Light Co.*, 899 So. 2d 1105, 1116 (Fla. 2005) (quoting *McCain v. Florida Power Corp.*, 593 So. 2d 500, 502 (Fla. 1992)).

⁵ *Pope v. Pinkerton-Hays Lumber Co.*, 120 So. 2d 227, 229-230 (Fla. 1st DCA 1960)(emphasis in original).

as a consequence of its negligent acts.”⁶

While no single failure by FSU may have caused Darling's death, it was the combined impact of FSU's negligent acts that led to his death. It is foreseeable that given FSU's conduct, an athlete would likely get injured during conditioning drills in a manner similar to that which ultimately resulted in Darling's death. The conditioning drills were by all accounts extremely strenuous and designed to push players to their physical limit. These drills frequently caused players to vomit and the statements by both players and trainers provide examples where players were removed from drills after complaining of dizziness and, in some cases, after passing out. FSU appears to have disregarded NCAA guidelines that clearly recommend avoiding dehydration, acclimatizing players to heat and humidity, and careful conditioning players. Given FSU's knowledge and experience with the drills and its failure to follow NCAA guidelines, it was reasonably foreseeable that given FSU's conduct an athlete would likely get injured during conditioning drills in a manner similar to that which ultimately resulted in Darling's death.

FSU's conduct also substantially caused Darling's death. Darling's autopsy indicated that Darling had extensive sickling in multiple organs. The autopsy noted that “Although rare, sudden unexpected death has been associated with healthy athletic males with sickle cell trait. Sickle cell trait appears to lower the threshold for ventricular arrhythmias in patients exposed to exertional heat injury.” Dr. Nori Trehan, hired by the Claimants, concluded that Darling “died from a sickle cell ‘crises’ which could have been avoided in the first place by recognizing it, limiting his activities and making fluids readily available” In the absence of evidence to the contrary, Dr. Trehan's testimony establishes that FSU's failure to provide players with proper access to water and sufficient rest and by creating an environment in which players felt compelled to complete drills regardless of the physical state, substantially caused Darling's death.

To the extent FSU may have breached its duty of care by failing to provide adequate medical personnel and equipment and failing to timely call for emergency assistance, the Claimants have not established that but for these failures, Darlings death would not have occurred. While it is not difficult to imagine that earlier medical intervention either by additional medical personnel or an AED may have decreased the likelihood of Darling's death, the evidence simply does not meet the legal threshold to bear this out. The AED record indicates that when it was used, it did not activate and instead recommended continued CPR. Additionally, both professionals hired by the

⁶ *Braden v. Florida Power & Light Co.*, 413 So. 2d 1291, 1292 (Fla. 5th DCA 1982) (citing *Crislip v. Holland*, 401 So.2d 1115, 1117 (Fla. 4th DCA 1981)).

Claimants, Dr. Nori Trehan and Richard Borkwoski, indicated that the earlier use of an AED *might* have increased Darlings chances of survival. Neither professional opined as to the impact additional medical personnel or an earlier call of emergency assistance would have had on Darling's chances of survival.

Damages

Given the fact of Darling's death, the issue of damages is uncontested. Had the Claimants' case proceeded to trial and the jury found negligence, given Darling's age at the time of his death, a jury's damages award for loss of support and services, pain and suffering, and medical and funeral bills likely would have exceeded \$2 million. Accordingly, the settlement amount of \$2 million appears reasonable.

ATTORNEY'S/
LOBBYING FEES:

Claimant's attorney has an agreement with Claimant to take a fee of 25% of Claimant's total recovery. Claimant's attorney has hired a lobbyist and has agreed to pay 5% of any amount of the claim bill in lobbying fees; such payment is included in the attorney's 25% fee. Outstanding costs are \$40,785.27.

LEGISLATIVE HISTORY:

In the 2016 Legislative Session, this claim was introduced as Senate Bill 16 by Senator Joyner and House Bill 3513 by Representative Jones, M. The Senate Bill was heard in two committees (Judiciary & Appropriations Subcommittee on Education) but died in Appropriations. The House bill died in the Civil Justice Subcommittee.

In the 2015 Legislative Session, this claim was introduced as Senate Bill 38 by Senator Joyner and House Bill 3517 by Representative Jones, S. The Senate bill was heard in Judiciary but died in Appropriations Subcommittee on Education. The House bill died in the Civil Justice Subcommittee.

In the 2014 Legislative Session, this claim was introduced as Senate Bill 24 by Senator Joyner and House Bill 3523 by Representative Jones, S. Neither bill was heard in either chamber.

In the 2013 Legislative Session, this claim was introduced as Senate Bill 14 by Senator Joyner and House Bill 597 by Representative Jones, S. Neither bill was heard in either chamber.

In the 2012 Legislative Session, this claim was introduced as Senate Bill 14 by Senator Joyner and House Bill 197 by Representative Stafford. Neither bill was heard in either chamber.

In the 2011 Legislative Session, this claim was introduced as Senate Bill 14 by Senator Joyner and House Bill 1441 by Representative Watson. Neither bill was heard in either chamber.

In the 2010 Legislative Session, this claim was introduced as Senate Bill 42 by Senator Joyner and House Bill 803 by Representative Chestnut. Neither bill was heard in either chamber.

In the 2009 Legislative Session, this claim was introduced as Senate Bill 26 by Senator Lawson and House Bill 1365 by Representative Brise. Neither bill was heard in either chamber.

In the 2008 Legislative Session, this claim was introduced as Senate Bill 32 by Senator Lawson and House Bill 303 by Representative Richardson. Neither bill was heard in either chamber.

In the 2007 Legislative Session, this claim was introduced as Senate Bill 26 by Senator Lawson. There was no House bill filed and the Senate bill was withdrawn prior to introduction.

In the 2006 Legislative Session, this claim was introduced as Senate Bill 32 by Senator Lawson and House Bill 289 by Representative Richardson. Neither bill was heard in either chamber.

In the 2005 Legislative Session, this claim was introduced for the first time as Senate Bill 16 by Senator Lawson and House Bill 283 by Representative Richardson. Neither bill was heard in either chamber.

RECOMMENDATIONS:

I recommend that House Bill 6515 be reported FAVORABLY.

Respectfully submitted,

PARKER AZIZ

House Special Master

cc: Representative Jones, House Sponsor
Senator Braynon, Senate Sponsor
Barbara Crosier, Senate Special Master