



## THE FLORIDA SENATE

### SPECIAL MASTER ON CLAIM BILLS

**Location**  
409 The Capitol

**Mailing Address**  
404 South Monroe Street  
Tallahassee, Florida 32399-1100  
(850) 487-5229

DATE	COMM	ACTION
3/20/25	SM	Favorable
3/25/25	JU	Favorable
3/28/25	CA	Pre-meeting
	RU	

March 27, 2025

The Honorable Ben Albritton  
President, The Florida Senate  
Suite 409, The Capitol  
Tallahassee, Florida 32399-1100

Re: **SB 30** – Senator Martin  
**HB 6533** – Representative LaMarca  
Relief of Estate of M.N. by the Broward County Sheriff's Office

### SPECIAL MASTER'S FINAL REPORT

THIS IS A CONTESTED CLAIM FOR LOCAL FUNDS IN THE AMOUNT OF \$2,608,258.50 PAYABLE BY THE BROWARD SHERIFF'S OFFICE TO THE ESTATE OF M.N. THIS AMOUNT IS THE REMAINING UNPAID BALANCE OF A JURY AWARD AND ASSOCIATED AWARDED COSTS THAT AROSE FROM A LAWSUIT ALLEGING THAT THE NEGLIGENCE OF THE BROWARD SHERIFF'S OFFICE, ITS EMPLOYEES, AND OTHER DEFENDANTS RESULTED IN THE DEATH OF M.N.

#### FINDINGS OF FACT:

M.N. was the daughter of Keshia Walsh and Christopher Nevarez. She was born on April 20, 2016<sup>1</sup> and died on October 28, 2016.<sup>2</sup> Ms. Walsh and Mr. Nevarez are also parents to D.N., born February 2, 2012.<sup>3</sup>

From approximately January to September 14, 2016, Ms. Walsh lived in the home of Ann McClain, Mr. Nevarez's mother. D.N., and, after her birth, M.N., also lived with Ms.

<sup>1</sup> Claimant's Exhibit 49, M.N. Birth Certificate.

<sup>2</sup> Claimant's Exhibit 32, M.N. Death Certificate.

<sup>3</sup> Claimant's Exhibit 1 at 1, Intake Report.

McClain during this timeframe.<sup>4</sup> Mr. Nevarez lived separately at his girlfriend's house.

Mr. Nevarez and Ms. Walsh split care for M.N. while the other worked. Generally, Mr. Nevarez cared for M.N. at Ms. McClain's home on certain days, and Ms. Walsh cared for M.N. on other days. If one could not provide care for M.N. on their assigned day, it fell to that person to find alternate care.<sup>5</sup>

On August 19, 2016, Ms. Walsh brought M.N. to Broward Health hospital. She reported that M.N. had fallen from a couch at Juan Santos' dwelling and received a black eye. The hospital x-rayed M.N., and did not find any fractures.

Mr. Nevarez and Ms. Walsh brought M.N. to a follow up medical appointment at Personal Care Pediatrics pursuant to follow up care instructions from Broward Health hospital.<sup>6</sup> At that visit, Mr. Nevarez questioned the doctor whether it was likely that M.N. had borne her injuries as the result of a fall, and the doctor responded that it was possible.

On September 14, 2016, Ms. Walsh and Mr. Nevarez had a conflict. Ms. Walsh, abruptly moved herself, D.N., and M.N. out of Ms. McClain's home and into the home of Ms. Walsh's co-worker, Juan Santos, and his daughter K.S.

Mr. Nevarez did not attempt to contact Ms. Walsh for approximately 2 weeks after the confrontation in order to "let her cool off." He further testified that this sort of behavior had happened before, and that he expected Ms. Walsh to return to Ms. McClain's home eventually. Ms. McClain maintained intermittent contact via text messages with Ms. Walsh, but could not discover where Ms. Walsh and the children (D.N. and M.N.) were living.

Mr. Nevarez and Ms. McClain both testified that they thereafter attempted to see M.N. and D.N. by:<sup>7</sup>

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<sup>4</sup> Claimant Exhibit 87 at 159-161, Christopher Nevarez Testimony at TPR Hearing.

<sup>5</sup> Claimant Exhibit 87 at 159, Christopher Nevarez Testimony at TPR Hearing.

<sup>6</sup> Mr. Nevarez Claim Bill 30 hearing testimony. See *also*, Claimant Exhibit 56 at 6, Personal Care Pediatrics File for M.N.

<sup>7</sup> Mr. Nevarez, Claim Bill 30 hearing testimony.

- Texting Ms. Walsh at the number previously used to contact her, although it is unclear whether the messages went through to Ms. Walsh's phone;<sup>8</sup>
- Asking for Ms. Walsh at her place of employment;
- Attempting to visit D.N. at his school;
- Having Ms. McClain and other friends attempt to follow Ms. Walsh's car home from her place of employment.

Some of Mr. Nevarez's text messages did inquire when he would next see his children. Other text messages were profane and threatening to Ms. Walsh.<sup>9</sup>

### **October 13, 2016 Medical Diagnosis and Treatment**

On October 13, 2016, Ms. Walsh brought M.N. to Northwest Medical Center with complaints of a fever and leg pain. M.N. was admitted as a patient of Dr. Font in the ER at 3:23 pm.<sup>10</sup> When questioned about the possible cause of M.N.'s leg pain, Ms. Walsh reported that there was no recent trauma and could not provide an explanation.<sup>11</sup>

Between 3:45 and 5:00 p.m., M.N. was x-rayed and diagnosed with subacute fractures in her left proximal tibia and fibula.<sup>12</sup>

Dr. Font then initiated a call to the child abuse hotline to report M.N.'s injuries as the result of suspected abuse.<sup>13</sup> At 5:45 pm, the treating nurse entered into M.N.'s chart that the first DCF notification had been made.<sup>14</sup>

Dr. Font then disclosed the diagnosed fractures to Ms. Walsh; at this time, Ms. Walsh reported that M.N. "had a fall from a couch about 2 months ago. She was seen at North Broward Hospital and had a CAT scan off the brain and some other x-rays."<sup>15</sup> Dr. Font noted that her continued conversations with Ms. Walsh about the source of the injury were not satisfactory,

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<sup>8</sup> Mr. Nevarez testifies that he believes his phone number had been blocked by Ms. Walsh, and therefore she did not receive his messages. See also, Claimant Exhibit 87 at 171 and 192, Christopher Nevarez Testimony at TPR Hearing.

<sup>9</sup> Claimant Exhibit 30, Text Messages between Chris Nevarez and Keshia Walsh.

<sup>10</sup> Claimant Exhibit 55 at 1, *Northwest Medical Center Coding Summary for M.N.'s Oct. 13, 2016 visit.*

<sup>11</sup> Claimant Exhibit 68 at 33-36, Deposition of Dr. Font (May 16, 2022); and Claimant Exhibit 55 at 1, *Northwest Medical Center Emergency Provider Report for M.N.'s Oct. 13, 2016 visit* ("Mom denied any recent trauma.")

<sup>12</sup> Claimant Exhibit 55 at 6-7, *Northwest Medical Center Emergency Provider Report for M.N.'s Oct. 13, 2016 visit.*

<sup>13</sup> Claimant Exhibit 68 at 24-35, Deposition of Dr. Font (May 16, 2022).

<sup>14</sup> Claimant Exhibit 55 at 7, *Northwest Medical Center Emergency Provider Report for M.N.'s Oct. 13, 2016 visit.*

<sup>15</sup> Claimant Exhibit 55 at 7, *Northwest Medical Center Emergency Provider Report for M.N.'s Oct. 13, 2016 visit.*

and that Ms. Walsh “couldn’t give [us] really good information [...] I felt like mom the whole time was trying to say something happened at the baby-sitter.”<sup>16</sup>

Dr. Font reviewed M.N.’s records from her August North Broward Hospital visit and noted an x-ray was completed at that time, and no fractures were found.<sup>17</sup> She further noted that the August hospital chart had noted “facial contusion/bruising.”<sup>18</sup>

At approximately 5:00 p.m., Dr. Font contacted M.N.’s pediatric office to discuss M.N.’s medical history.

At 5:20 p.m., Dr. Font consulted with an orthopedic specialist, Mark Fortney. He stated that he did not feel that the October 13th tibia fracture was related to the fall from the couch 2 months ago. Mr. Fortney stated that he suspected M.N.’s fractures to be about 3-4 weeks old, and “could be nonaccidental” and recommended reporting the injury.<sup>19</sup>

At 5:45 p.m., Dr. Matthew Buckler conducted a bone osseus survey of M.N.’s x-rays. Dr. Buckler telephonically disclosed his findings of a “partially healed left proximal tibial and fibular metaphyseal fracture with periostitis” and “additional distal left radial metaphyseal fracture” to Dr. Font at approximately 6:02 pm.<sup>20</sup>

Dr. Font’s shift ended at 7:00 p.m.; she waited an additional hour to attempt to meet with the DCF investigator but left Northwest Medical Center at 8:00 p.m. Dr. Font testifies that no child protective investigator contacted her about M.N. at any point.<sup>21</sup>

At 9:25 p.m., the treating nurse noted in M.N.’s medical file that a status update call was made to DCF.<sup>22</sup> It was subsequently determined (at 10:13 p.m.) that the “hot line

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<sup>16</sup> Claimant Exhibit 68 at 39-40, Deposition of Dr. Font (May 16, 2022).

<sup>17</sup> Claimant Exhibit 55 at 9, *Northwest Medical Center Emergency Provider Report for M.N.’s Oct. 13, 2016 visit*.

<sup>18</sup> *Id.* at 8.

<sup>19</sup> *Id.* at 8-9.

<sup>20</sup> Claimant Exhibit 11, Northwest Medical Center Diagnostic Imaging Reports (October 13, 2016).

<sup>21</sup> Claimant Exhibit 68 at 64, 69-70, Deposition of Dr. Font (May 16, 2022).

<sup>22</sup> Claimant Exhibit 55 at 4, *Northwest Medical Center EDM Live Emergency Patient Record for M.N.*(Oct. 13, 2016).

keyed it in wrong earlier, and the investigator would arrive at the hospital to initiate the investigation in about three hours.

### **October 13, 2016 Investigation by BSO**

At about 10:15 p.m., BSO dispatched child protective investigator (CPI) Henry to Northwest Medical Center to investigate Dr. Font's report. CPI Henry's handwritten notes detail her next investigative step as a face-to-face with M.N. and Ms. Walsh at 10:54 p.m.. CPI Henry's chronological notes, entered at a computer the next afternoon, detail an intervening contact with the reporter—however, this is disputed by Dr. Font's testimony, which states that she never spoke to a CPI about M.N.

CPI Henry conducted a "face-to-face" meeting with M.N. and Ms. Walsh at 10:54 pm. During her meeting with Ms. Walsh, CPI Henry learned that:

- M.N. had been taken to North Broward Hospital in August of 2016 as a result of a fall from the couch.
- Ms. Walsh brought M.N. to the hospital on this day as a result of a fever and stiff legs.
- Ms. Walsh used several babysitters to care for M.N., including a friend named Valerie and a "Portuguese lady." Ms. Walsh provided CPI Henry with a business card that provided a phone number and that advertised "babysitting services", but did not provide a business or personal name for the "Portuguese lady."
- Ms. Walsh lived with a roommate, Juan Santos.<sup>23</sup>

CPI Henry next met with nurse Margaret Vincent at 11:05 p.m.<sup>24</sup> This implies that the face-to-face meeting with Ms. Walsh and M.N. lasted no more than 10 minutes.

CPI Henry's notes of her investigation noted M.N.'s three diagnosed fractures, her own observations of a mark under M.N.'s eye,<sup>25</sup> and of discoloration on M.N.'s left wrist.<sup>26</sup>

M.N. was discharged from Northwest Medical Center at 11:38 p.m.<sup>27</sup>

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<sup>23</sup> Claimant Exhibit 3, CPI Henry Handwritten Case Notes for Case 2016-287154.

<sup>24</sup> *Id.*

<sup>25</sup> Toniele Henry Deposition, p. 103, line 15-21, stating that, "It wasn't a black eye [...] It was just like a faint little puffy thing under her eye."

<sup>26</sup> Claimant Exhibit 2 at 5, Child Protective Investigation Chronological Record of CPI Henry on 10/13/2016.

<sup>27</sup> Claimant Exhibit 12, Northwest Medical Center Discharge Summary (Oct. 13, 2016).

Immediately after M.N.'s discharge from Northwest Medical Center, CPI Henry visited Ms. Walsh at Mr. Santos' home. She was met there by the Broward County Sheriff's Office Law Enforcement.

Law enforcement reported in their investigation report that M.N. had "swelling and discoloration to her left eye [which] appeared to be an injury that was sustained recently." Additionally, law enforcement asked Ms. Walsh how M.N.'s fractures were sustained, to which she responded that she had no idea, but that she wouldn't be bringing her to the babysitter who she had been using any more.<sup>28</sup>

CPI Henry conducted a Child Present Danger Assessment on October 13. The report found that there was no present danger threat to M.N., and that "*[t]he mother took the victim to Northwest medical center because the child was exhibiting some stiffness in her leg and she has a fever. The fever could be from the child teething. There was a[n] x-ray completed in which revealed the injuries occurred about two to three weeks ago. The mother advises the victim child fell off the couch in August and was seen at North Broward hospital. The mother advised the child goes to private babysitter when she goes to work. The mother has completed a follow up appointment with the pediatrician. CPT was contacted.*"<sup>29</sup>

Of relevant note, CPI Henry's Present Danger Assessment indicated "No" to the question presented: "Child has a serious illness or injury (indicative of child abuse) that is unexplained, or the Parent/Legal Guardian/Caregiver explanations are inconsistent with the illness or injury."

While still at Mr. Santos' home, CPI Henry developed an impending safety plan that Ms. Walsh signed. The safety plan required that Ms. Walsh would: not leave the child on the couch or bed, and would place M.N. in the pack and play when she falls asleep; enroll M.N. in a licensed daycare; not leave the children in the care of the babysitter or home where the

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<sup>28</sup> Claimant Exhibit 40, *BSO Investigative File for Case 2016-287154*.

<sup>29</sup> Claimant Exhibit 6, *Florida Safety Decision Making Methodology Child Present Danger Assessment, FSFN Case ID 101483774* (Oct. 14, 2016).

incident occurred; notify CPI of the identity of who will be providing care to the children while she [Ms. Walsh] works.<sup>30</sup>

CPI Henry took the following actions in furtherance of the abuse investigation regarding M.N.:<sup>31</sup>

- Called the Child Protective Team to refer M.N.'s case on October 14, 2016. She was told that they would conduct a review of M.N.'s medical files.<sup>32</sup>
- Received and uploaded M.N.'s medical files from Northwest Medical Center on October 15, 2016. CPI Henry does not remember reviewing these files.
- Attempted to call the 'Portuguese Babysitter' once on October 17, 2016. No contact was made, however.

CPI Henry did not attempt to contact Juan Santos, nor refer him to the BSO Analytical team for a background and related issues check.

CPI Henry did not attempt to contact Mr. Nevarez at any point from October 15 to October 24, 2016.

CPI Henry's investigation was subject to a supervisory review on October 18, 2016, wherein supervisor Bossous recommended that CPI Henry obtain medical file from M.N.'s August hospital visit, obtain collateral contact from neighbors, interview the [Portuguese] babysitters, and offer daycare services.<sup>33</sup> CPI Henry's chronological case notes do not reflect any activity on M.N.'s investigation after receipt of these recommendations.

#### **October 24<sup>th</sup>, 2016 Injuries**

On October 24, 2016, M.N. was brought to North Broward Medical Center in an unresponsive state and transferred via air ambulance to Broward General Medical Center. It was later determined that Juan Santos had beaten M.N. and caused significant injuries to her skull.

On October 28, 2016, M.N. died as a result of her injuries.<sup>34</sup>

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<sup>30</sup> Claimant Exhibit 7, *Child Safety Plan* (October 14, 2016). Notably, Ms. Walsh placed M.N. in the care of babysitters beginning on October 15<sup>th</sup>, 2 days after signing the safety plan, and failed to communicate this to the CPI. See Claimant Exhibit 41, *Walsh Babysitting Timeline* (Oct. 27, 2016).

<sup>31</sup> Claimant Exhibit 2, *T. Henry Chronological Notes for M.N.'s abuse investigation* (Oct. 13-Oct. 24, 2016).

<sup>32</sup> Claimant Exhibit 53 at 1, *Broward County Child Protection Team Final Case Summary Report* (Dec. 13, 2016).

<sup>33</sup> Claimant Exhibit 25, *Supervisor Consultation* (Oct. 18, 2016).

<sup>34</sup> Claimant Exhibit 32, *M.N. Death Certificate* (Oct. 28, 2016).

On October 24, 2016, BSO placed D.N. in the care of Christopher Nevarez and implemented a safety plan preventing Ms. Walsh from having contact with D.N. Ms. Walsh’s parental rights to D.N. were terminated on June 20, 2018.

LITIGATION HISTORY:

A jury trial was conducted in August 2023, wherein the claimant alleged that BSO negligently failed to protect M.N. from abuse, thereby causing her death.<sup>35</sup> On August 16, 2023, the jury rendered a verdict in favor of the estate of M.N., with 36.6 percent of the fault apportioned to Christopher Nevarez, 2.7 percent of the fault apportioned to Ann McClain, and 58 percent of the fault apportioned to the BSO.<sup>36</sup> An additional cost judgment of \$88,258.50 was entered on July 16, 2024. The claimants executed two settlement agreements before the matter went to trial—the first with M.N.’s pediatricians for the payment of \$100,000, and the second with Broward County for \$90,000 payment made to the estate of M.N.

CONCLUSIONS OF LAW:

The claim bill hearing held on February 3, 2025, was a *de novo* proceeding to determine whether BSO is liable in negligence for damages suffered by the claimant’s estate, and, if so, whether the amount of the claim is reasonable. This report is based on evidence presented to the special master prior to, during, and after the hearing. The Legislature is not bound by jury verdicts when considering a claim bill, the passage of which would be an act of legislative grace.

In this matter, the claimant alleges negligence on behalf of an employee of the BSO. The State is liable for a negligent act committed by an employee acting within the scope of his or her employment.<sup>37</sup>

**Negligence**

Negligence is “the failure to use reasonable care, which is the care that a reasonably careful person would use under like circumstances,”<sup>38</sup> and “a legal cause of loss, injury or damage if it directly and in natural and continuous sequence produces

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<sup>35</sup> *Ann McClain v. Sheriff of Broward County*, CACE 18-025385(02) (Fla. 17th Cir. Ct. 2025).

<sup>36</sup> Claimant’s Exhibit 94, *Ann McClain v. Sheriff of Broward County*, CACE 18-025385(02) (Fla. 17th Cir. Ct. 2025).

<sup>37</sup> *Iglesia Cristiana La Casa Del Senor, Inc. v. L.M.*, 783 So. 2d 353 (Fla. 3d DCA 2001).

<sup>38</sup> Florida Civil Jury Instructions 401.4 – Negligence.



or contributes substantially to producing such loss, injury or damage, so that it can reasonably be said that, but for the negligence, the loss, injury or damage would not have occurred.”<sup>39</sup>

In a negligence action, “a plaintiff must establish the four elements of duty, breach, proximate causation, and damages.”<sup>40</sup>

#### BSO's Duty of Care

Whether a duty of care exists is a question of law.<sup>41</sup> Statute, case law, and agency policy describe the duty of care owed by a CPI during the course of an investigation of abuse. At the time of its involvement with M.N., the BSO was the contracted provider of child protective investigations for Broward County.<sup>42</sup> The BSO has a duty to reasonably investigate complaints of child abuse and neglect.<sup>43</sup>

However, where the “express intention of the legislature is to protect a class of individuals from a particularized harm, the governmental entity entrusted with the protection owes a duty to individuals within the class.”<sup>44</sup> It has been found that “HRS is not a mere police agency and its relationship with an abused child is far more than that of a police agency to the victim of a crime ... the primary duty of HRS is to immediately prevent any further harm to the child...[.]”<sup>45</sup>

Broward County, separately, was the contracted authority to perform child protective team services in Broward County, including completing medical examinations, nursing assessments, specialized and forensic interviews, providing expertise in evaluating alleged maltreatments of child abuse and neglect.

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<sup>39</sup> Florida Civil Jury Instructions 401.12(a) – Legal Cause, Generally.

<sup>40</sup> *Limonos v. School Dist. of Lee County*, 161 So. 3d 384, 389 (Fla. 2015).

<sup>41</sup> *McCain v. Fla. Power Corp.*, 593 So. 2d 500, 502 (Fla. 1992).

<sup>42</sup> Section 39.3065, F.S.

<sup>43</sup> *Dept. of Health and Rehabilitative Svcs. v. Yamuni*, 498 So. 2d 441, 442-43 (Fla. 3d DCA 1986) (stating that the Dept. of Health and Rehabilitative Services, a precursor to the Dept. of Children and Families, has a statutory duty of care to prevent further harm to children when reports of child abuse are received); *Dept. of Children and Family Svcs. v. Amora*, 944 So. 2d 431 (Fla. 4th DCA 2006).

<sup>44</sup> *Id.* (noting that the child was a member of the class protected under a specific statute and the [Department of Health and Rehabilitative Services] owed a statutory duty to protect him from abuse and neglect).

<sup>45</sup> *Dept. of Health and Rehabilitative Svcs. v. Yamuni*, 529 So. 2d 258, at 261 (Fla. 1988).

*BSO's Policies and Procedures Regarding Investigation*

The BSO is required to commence an investigation immediately if it appears that the immediate safety or well-being of a child is endangered, [...] or that the facts otherwise so warrant.<sup>46</sup>

*BSO Must Interview and Contact Relevant Individuals*

If an abuse investigation is initiated at a hospital emergency room, the CPI must consult with the attending physician to determine whether the injury is the result of maltreatment. If the physician who examined the child is not associated with Child Protective Team (CPT), the investigator must immediately contact the local CPT office to share the examining physician's impressions and contact information with a case coordinator. CPT will determine whether or not to respond on-site to conduct additional medical evaluation of the child and/or determine the need for follow-up CPT services.<sup>47</sup>

The BSO is separately required to contact a CPT in person or by phone to discuss all reports of fractures in a child of any age.

During an investigation, BSO's assessment of the safety and perceived needs for the child and family "must include a face-to-face interview with the child, other siblings, parents, and *other adults in the household* and an onsite assessment of the child's residence."<sup>48</sup>

The BSO must review prior criminal history of parents and caretakers. If a CPI discovers the presence of an additional adult household member who was not screened by the Florida Abuse Hotline at the time of an initial report, then the CPI must, within 24 hours of such discovery, request:

- An abuse history from the Hotline. The Hotline must endeavor to produce this history within 24 hours of the CPI's request; and
- A criminal records check, including all call-out history, from the local criminal agency. The criminal record check must be initiated within 24 hours of the individual's identity and

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<sup>46</sup> Section 39.201(5), F.S. (2016).

<sup>47</sup> Claimant Exhibit 4, *CFOP 170-5, 9-8, Child Protective Team Consultations* (April 4, 2016). Claimant Exhibit 65, Deposition of Chantale Bossous at 96-97.

<sup>48</sup> Section 39.301(7), F.S.. *Emphasis added*.

presence in the home becoming known to the investigator.<sup>49</sup>

CPI must attempt to contact the non-offending parent, and if unsuccessful, must make daily attempts thereafter.<sup>50</sup>

*Present and Impending Danger Assessments*

The BSO must conduct a present danger assessment during its investigation of reported maltreatment. A discovered bone fracture is considered maltreatment pursuant to DCF/BSO policy, but “accidental bone fractures that are not alleged to be inflicted or the result of inadequate supervision do not constitute “Bone Fracture” as maltreatment.”<sup>51</sup>

Present danger which occurs during ongoing services may involve the parent or legal guardian in an in-home case, a relative or non-relative caregiver. The CPI should find a threatening family condition where there is a serious injury to an infant with no plausible explanation, and/or the perpetrator is unknown.<sup>52</sup>

In conducting the maltreatment index assessment, the CPI must verify his or her findings to establish by a preponderance of credible evidence that the broken bone was or was not the result of a willful act by a parent or caregiver. Such evidence can be documented through:<sup>53</sup>

- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals (which include nonmaltreating parent)
- Analysis of reports and interviews from law enforcement.
- Assessment of the CPT.
- Obtaining and analyzing any medical reports to assess for prior injuries, location of the fracture, the number of fractures and the aging of fractures.

The CPI is required to conduct a separate Focus of Family Assessment of each family that reside together and share

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<sup>49</sup> Rule 65C-29.003, Florida Administrative Code (June 5, 2016). Rule 65C-29.009, Florida Administrative Code (2014).

<sup>50</sup> Claimant Exhibit 65, Deposition of Chantale Bossous at 54-55.

<sup>51</sup> CFOP-4: Bone Fracture.

<sup>52</sup> CFOP 170-1, 2-2

<sup>53</sup> CFOP-4: Bone Fracture.

caregiving responsibilities, regardless of the household that is responsible for the maltreatment.<sup>54</sup>

### BSO's Breach of Duty

Once a duty is found to exist, whether a defendant was negligent in fulfilling that duty is a question for the finder of fact.<sup>55</sup> A fact finder must decide whether a defendant exercised the degree of care that an ordinarily prudent person, or child protective investigator in this instance, would have under the same or similar circumstances.<sup>56</sup>

The BSO failed to take the following steps, that a reasonable and prudent person would have:

- Contact CPT immediately (while at the hospital for M.N.'s investigation). Rather, CPI Henry contacted the CPT the next afternoon.
- Conduct a face-to-face interview with Mr. Santos, a known adult housemate. Additionally, CPI Henry did not seek to obtain Mr. Santos' abuse or criminal history.
- Contact or interview Mr. Nevarez.
- Interview any third-party witnesses, including Mr. Santos, any of the babysitters whose names Ms. Walsh provided, any of Ms. Walsh's friends or neighbors, or Ms. McClain.
- Speak directly with the reporting physician, Dr. Font. In particular, the BSO CPI was required to provide her name and contact information to the professionally mandated reporter within 24 hours of being assigned to the investigation.<sup>57</sup>
- Review M.N.'s medical file.

It would have been prudent, and in fact was required by Departmental policy and regulation, for the CPI to follow-up on these steps to shed more light on the incident and gather more information about the unexplained injuries to M.N. Instead, CPI Henry appears to have accepted Ms. Walsh's explanation of the significant injuries that the "Portuguese babysitters" were the perpetrators of the injury without

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<sup>54</sup> CFOP 170-1, 2-3(4). (May 2016).

<sup>55</sup> *Yamuni*, 529 So. 2d at 262.

<sup>56</sup> *Russel v. Jacksonville Gas Corp.*, 117 So. 2d 29, 32 (Fla 1st DCA 1960) (defining negligence as, "the doing of something that a reasonable and prudent person would not ordinarily have done under the same or similar circumstances, or the failure to do that which a reasonable and prudent person would have done under the same or similar circumstances").

<sup>57</sup> CFOP 170-5, Chapter 18-2, *Interviewing Collateral Contacts: Procedures*.

attempting to verify that finding through additional investigation.

Even though DCF has up to 60 days to complete an investigation,<sup>58</sup> the DCF failed to take precursory and required steps that an ordinary prudent CPI would have taken in this instance. For these reasons, I find that the DCF breached its duty of care.

Ms. Walsh contributed to this breach by failing to give Mr. Nevarez's contact information to CPI Henry. Additionally, Ms. Walsh contributed to this breach by failing to give a full accounting of who she left M.N. with for babysitting, specifically by failing to name Mr. Santos as one of M.N.'s caretakers.

#### Proximate Cause

In order to prove negligence, the claimant must show that the breach of duty caused the specific injury or damage to the plaintiff.<sup>59</sup> Proximate cause is generally concerned with "whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred."<sup>60</sup> To prove proximate cause, the plaintiff generally must submit evidence that "there is a natural, direct, and continuous sequence between BSO's negligence and [M.N.'s] death such that it can be reasonably said that but for BSO's negligence, the abuse to and death of [M.N.] would not have occurred."<sup>61</sup>

The undersigned finds that Ms. Walsh contributed to the BSO's negligent investigation of M.N.'s abuse by failing to be upfront with the CPI about (1) her children's relationship with their father; (2) her knowledge of Mr. Nevarez's contact information; and (3) her reliance on Mr. Santos for childcare. However, this misinformation could, and should have been overcome by adherence to the required investigative policies and procedures.

There is competent substantial evidence in the record to support a finding that BSO had a duty to reasonably investigate the complaint of child abuse. The BSO owed this

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<sup>58</sup> Section 39.301(17), F.S. (2010).

<sup>59</sup> *Stahl v. Metro Dade Cnty.*, 438 So. 2d 14 (Fla. 3<sup>rd</sup> DCA 1983).

<sup>60</sup> *Amora*, 944 So. 2d at 431.

<sup>61</sup> *Id.*

duty to M.N. Specifically, BSO failed to appropriately identify the present danger to M.N. in home situation by failing to have a criminal background check run on Mr. Santos within 24 hours of the CPI's knowledge of his presence in M.N.'s household. If CPI Henry had , then the CPI would have been legally required to remove M.N. from Ms. Walsh and Mr. Santos' home, and Mr. Santos would not have had opportunity to inflict the injuries that ultimately caused M.N.'s death.

This failure foreseeably and substantially caused the injuries that resulted in M.N.'s death. The claimants presented evidence that there is a natural, direct, and continuous sequence between BSO's negligence and M.N.'s death such that it can reasonably be said that but for BSO's negligence, the injuries that resulted in M.N.'s death would not have occurred.

In the civil matter filed in the interest of M.N.'s estate, a jury found that BSO's inactions proximately caused M.N.'s death. "[T]he issue of proximate cause is generally a question of fact concerned with 'whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred.'"<sup>62</sup> In cases against the Department of Children and Families (DCF) having some similarities to this matter, the appellate court determined that "[t]he plaintiffs presented evidence that there is a natural, direct, and continuous sequence between DCF's negligence and [a child's] injuries such that it can be reasonably said that but for DCF's negligence, the abuse to [the child] would not have occurred."<sup>63</sup>

### Damages

Finally, M.N.'s surviving parent suffered damages because of the BSO's negligence. Through the provision of personal testimony by Mr. Nevarez and Ms. McClain, supporting evidence and similar case law, claimants established that the jury verdict and final judgment of \$2.61 million, and awarded costs of \$88,258.50 for the Mr. Nevarez's mental pain and suffering,<sup>64</sup> as the father of M.N., is reasonable.

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<sup>62</sup> *Amora*, 944 So. 2d at 431.

<sup>63</sup> *Id.*

<sup>64</sup> Section 768.21, F.S., authorizes damages for wrongful death.

The jury award and cost judgment awarding taxable costs in this matter is not excessive compared to jury verdicts in similar cases.

### **Sovereign Immunity**

Although it appears that the BSO had insurance coverage at the time of the event, it is alleged by the BSO that their insurance coverage for this event has been denied, but no formal communication of the denial has been received from the insurance company. According to testimony provided at the hearing, the BSO has offered payment of \$110,000 of the jury award to the claimant, but claimant had not received said payment as of the date of the hearing. Broward County has paid its share, \$90,000 of the \$2.61 million jury award. Therefore, if this bill passes, the BSO owes the claimant a total of \$2,608,258.50.

### **Settlement with Personal Care Pediatrics**

The claimants settled their claim against the doctors of Personal Care Pediatrics through a confidential settlement made before the trial. During the special master hearing, claimant's counsel testified that the settlement was for \$100,000, which is being held in the claimant's trust account and has not been released to the claimants.

### **Settlement with Keisha Walsh**

At the hearing conducted, the undersigned asked claimant's attorneys to detail the legal issues relating to Ms. Walsh's right to a portion of M.N.'s estate. The claimant's attorneys represented that the probate matter was ongoing, but that they would provide their pleadings as evidence of their position in the matter. Claimant provided the pleadings on February 14, 2025. The undersigned subsequently discovered that claimant's attorneys had entered into a settlement with Ms. Walsh, and asked that claimant's attorneys provide a copy of the settlement and any related documents. Claimant's attorneys responded with a narrative detailing that the party had settled with Ms. Walsh in the probate matter to pay Ms. Walsh \$30,000, but no copy of the settlement agreement.

ATTORNEY FEES:

Section 768.28(8), of the Florida Statutes, states that no attorney may charge, demand, receive, or collect for services rendered, fees in excess of 25 percent of any judgment or settlement.

The claimant's attorneys have submitted an affidavit to limit attorney fees to 20 percent of the total amount awarded under the claim bill and lobbying fees to 5 percent of the total amount awarded under the claim bill.<sup>65</sup>

RECOMMENDATIONS:

Based upon the foregoing, the undersigned recommends that SB 30 be reported FAVORABLY.

Respectfully submitted,

Jessie Harmsen  
Senate Special Master

cc: Tracy Cantella, Secretary of the Senate

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<sup>65</sup> Claimant Exhibit 97, Sworn Affidavit of Stacie Schmerling.