Special Master's Final Report

The Honorable Daniel Perez
Speaker, The Florida House of Representatives
Suite 420, The Capitol
Tallahassee, Florida 32399-1300

Re: CS/HB 6511 - Representative Busatta
Relief/L.P./Department of Children and Families

SUMMARY

This is a contested claim for $28,000,000 by L.P., a minor (hereafter referred to as L.P. or "Claimant") against the Florida Department of Children and Families ("DCF") based on a jury verdict which found negligence by DCF and awarded L.P. a $28,000,000 judgment. The claim against DCF is for injuries and damages based on the negligence of DCF as the entity statutorily charged with protecting children in the state of Florida. This claim arises out of negligence in the context of the investigation by DCF in response to an abuse report called into the state's child abuse hotline. Less than 24 hours after DCF determined there was no "imminent danger" or threat to L.P.'s safety under the care of her mother, L.P.'s mother stabbed her 14 times, disemboweling her and inflicting significant, life-threatening injuries.

FINDINGS OF FACT

Suicide Video

Ashley Parker ("Ms. Parker") was the biological mother to 6-year old L.P. Ms. Parker and L.P. resided in a home together in Sarasota County just minutes away from Ms. Parker's biological mother (and grandmother to L.P.), Ms. Carey. On June 26, 2015, Ms. Parker sent what appeared to be a suicide video to a relative. The video was a self-recorded video that appeared to be taken in Ms. Parker's bathroom. In the video, Ms. Parker detailed what she would like done with her house and property upon her death. She also offered detailed instructions for who should take care of her daughter, L.P., upon her death.

Sarasota Police Department Welfare Check

Upon receipt of the video by Mr. Ashford, Ms. Parker's uncle, Mr. Ashford called the Sarasota Police Department ("SPD") and requested they conduct a wellness check on Ms. Parker and L.P., as he had significant concerns for the safety of the child based upon the mother's suicide video. Mr. Ashford requested SPD conduct a welfare check to visually "put eyes" on and assess

Ms. Parker and L.P. SPD Officer Tschetter[1] and his partner, Officer Kennedy, responded to the call and arrived at the home to conduct a wellness check.[2]

Officer Tschetter testified that since they did not have knowledge of whether a suicide or attempted suicide had taken place, multiple officers were present at the scene. Officer Tschetter testified that upon his arrival at the home, he attempted to call Ms. Parker numerous times and repeatedly knocked on the front door to get her to answer. Despite his initial attempts to make contact, Officer Tschetter was unable to do so and had to attempt to make entry into the home through a window. While opening a window to enter the house, an unknown male started walking down the hallway. The man eventually opened the front door to speak with one of the other officers present.

Eventually, Ms. Parker came down the hallway from the same direction that the man had come from and came to the front door. She told officers she had been in the shower, despite being fully clothed and appearing completely dry. Officers then asked her about the "suicide video." Ms. Parker told the officers that a family member had recently passed away and other family members were fighting over belongings and assets, so she made the video in an attempt to prevent similar disagreements from happening when she dies. Officers spoke with L.P. and noted that she "appeared fine" and told the officers the same. At that point, Officer Tschetter determined that no criminal activity was taking place and a suicide had not occurred. Thus, in his capacity as a law enforcement officer, there was nothing further Officer Tschetter could do to investigate the situation.

Officer Call to Abuse Hotline as a Mandatory Reporter

Upon getting back into his patrol car to leave the house, Officer Tschetter called the state child abuse hotline. As a law enforcement officer, Officer Tschetter was a "mandatory reporter." That is, anytime there is a suspicion of possible violence or a threat to a child, a law enforcement officer is required to make a phone call to the abuse hotline and notify them of the suspected threat. When Officer Tschetter spoke with the DCF representative on the hotline, he gave a report of the suicide video, that Ms. Parker's uncle was concerned about L.P., and that he had looked up Ms. Parker in their law enforcement system ("New World System") and learned that she had recently been Baker Acted[3] during the previous month. Between the uncle's concerns for L.P.'s safety and the mental health history of Ms. Parker, the officers felt they had a responsibility to call the abuse hotline.[4]

After calling into the hotline, Officer Tschetter never spoke to the DCF CPIs who investigated the allegations and he never received a voicemail from a CPI requesting information regarding

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[1] SPD Officer Todd Tschetter served as a patrol officer, canine officer, and marine patrol officer during his 30-year tenure with the department. He retired from SPD in May of 2023.

[2] It should be noted that, through his testimony, Officer Tschetter explained that he was familiar with Ms. Parker from prior call-outs involving her and the address of her house.

[3] The Florida Mental Health Act, commonly referred to as the "Baker Act," focuses on crisis services for individuals with mental illness, much like an emergency department is for individuals experiencing a medical emergency. Under the Baker Act, an individual may be taken to a receiving facility for involuntary examination if:

- There is reason to believe he or she has a mental illness and due to the mental illness has refused or is unable to determine if examination is necessary, and either:
  - Without care or treatment, the individual is unlikely to care for themselves which could result in substantial harm to their well-being, and it is not evident that harm can be avoided through family intervention or other services; or
  - It is likely, based on recent behavior, that without treatment, the individual will pose a serious threat to themselves or others. *See* Fla. Dep't. of Children and Families, *Baker Act*, https://www.myflfamilies.com/crisis-services/baker-act (last visited March 18, 2025).

[4] According to DCF, the case came in as an allegation of "inadequate supervision." However, DCF testified that regardless of the impetus for the investigation (drug use, inadequate supervision, physical abuse, neglect, etc.) all cases are investigated in the same manner.

his call to the hotline, despite being available, on-duty, and willing to speak with them.

DCF "Pre-Commencement"

Upon receiving a phone call to the abuse hotline, DCF's Tallahassee phone center customarily refers the call to a specific DCF office within the specific area to investigate the allegations. In this case, that call was referred to the Sarasota office where a CPI was assigned to the case to investigate. At that point, the case is customarily designated as either "immediate response," which requires the CPI to arrive at the residence within 2 hours, or a standard response time, which allows the initial contact to be made within 24 hours. In this case, the matter was designated as one requiring an "immediate response."[5]

Pursuant to DCF policy, investigators perform a "pre-commencement" meeting prior to departing the office to investigate any allegations. Pursuant to DCF's CPI "pre-commencement" training materials, the follow things must be reviewed prior to making initial contact with the suspected parent and child in question:

- Current allegation narrative;
- All prior abuse reports and investigative decisions to assess maltreatments, alleged victims, alleged maltreating caregivers and outcomes;
- NCIC[6], FCIC[7], local law enforcement, and call-out history;
- Available clerk of court records;
- Economic Self Sufficiency (ESS) records;
- Other state child welfare if indicated;
- Reporter information and contact; and
- Prior investigation outcomes.

The required information to be gathered and reviewed prior to initial contact serve to:

- Help assess child safety;
- Protect personal safety;
- Follow the law;
- Identify questions that should be asked;
- Help assess if a pattern of abuse or neglect exists;
- Informs CPI of prior services provided and level of cooperativeness;
- Identify family members; and
- Learn correct/different spelling of names.[8]

Senior CPI Tucker and CPI Lopez did not collect or review any evidence regarding Ms. Parker's criminal history, recent call-outs or the details of Ms. Parker's recent Baker Act; all of which they should have reviewed prior to making initial contact.

Prior DCF investigation records contained information that Ms. Parker was previously gound guilty of felony child endangerment. Those previous records included a toddler who was under Ms. Parker's care as a foster parent being severely burned in the chest by, what was suspected

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[5] There was some disagreement on the response time for "immediate response" matters, with CPI Tucker testifying that it meant she had to make initial contact within 4 hours. However, on December 31, 2014, revisions to the Florida Administrative Code were made and new standards went into place which required a response time initial contact for "immediate response" cases to be within 2 hours. CPI Tucker seemed unaware of the change in Code despite having been sent a department memorandum explaining such to all CPIs. CPI Tucker testified that she had no knowledge of the Code change and, thus, could not have communicated the change in response timing to her trainee, CPI Lopez; as such, neither CPI Tucker nor CPI Lopez were aware of the specific requirements they were obligated to follow during an investigation.

[6] NCIC stands for the National Crime Information Center.

[7] FCIC stands for the Florida Crime Information Center.

[8] DCF, *Module One: Preparing for Initial Contact*, on file with the House Civil Justice and Claims Subcommittee.

to be, a space heater, despite Ms. Parker telling authorities it was IcyHot cream, for which Ms. Parker was charged with and was adjudicated as guilty to felony child endangerment. Thus, despite failing to obtain the relevant police history, CPIs Tucker and Lopez did have access to previous DCF records for Ms. Parker during the pre-commencement phase.

Additionally, DCF had prior record of another incident wherein a foster child under Ms. Parker's care was removed from her care due to a "fall down the stairs" in which the child sustained injuries. Even further, DCF records included four different reports of Ms. Parker dropping L.P. as a baby or allowing her to roll off of surfaces, again, causing injuries to the child.

DCF Home Visit and Initial Contact

DCF CPI Tucker arrived at Ms. Parker's home at 7:43 p.m. The call to the Sarasota office came in at 4:31 p.m., and, as the case was designated as requiring an immediate response, CPI Tucker was required to arrive at the home as soon as possible, but no later than 2 hours after the call came in (that would have been at 6:31 p.m.). Thus, CPI Tucker was more than an hour late to make initial contact as required by the Florida Administrative Code.

Upon arriving at Ms. Parker's residence, CPIs Lopez and Tucker attempted to make contact with Ms. Parker. A woman came to the door (but did not come out from behind the door, making it impossible for the CPIs to visually confirm her identity) and identified herself as "Valencia Dubois," who was a friend of the mother and the child's godmother. According to testimony reviewed, the woman who identified herself as "Valencia" was actually Ms. Parker herself; she was providing false information to the CPIs and concealing her identity from behind the door. When Ms. Parker introduced herself to the CPIs as "Valencia," the CPIs did not do anything to attempt to verify her identity. The CPIs failed to:

- Pull a D.A.V.I.D.[9] report on Ms. Parker which would have provided them with her state issued identification and photograph with which the CPIs could compare to the subject at the scene;
- Ask "Valencia" for any form of identification to confirm that she was the person she was claiming to be;
- Ask L.P., an intelligent 6-year old capable of communicating, whether her mother was in the house or, alternatively, whether "Valencia" was her mother; and
- Contact law enforcement to assist with a parent who fails to identify himself or herself.

At some point shortly after the CPIs arrived to Ms. Parker's home, Ms. Parker's mother, Valerie Carey, was present outside the home. Ms. Carey, who is hearing impaired and relies on lip reading to understand what others are saying, spoke with the CPIs while L.P. was present. At or around this point, Ms. Parker (or "Valencia") locked her own mother, child and the CPIs out of the home. Upon being locked out, Ms. Carey proceeded to bang on the front door attempting to get Ms. Parker to open the door. In doing so, Ms. Carey yelled through the door "Ashley, open the door… Ashley what are you doing…Ashley open the door." At no point did either CPI present think to ask why Ms. Carey was calling to "Ashley" when they believed the person inside to be "Valencia."[10]

During the remainder of the initial home visit, the CPIs spoke with Ms. Carey and L.P. Ms. Carey informed the CPIs that L.P. frequently spent time at her home and that she lived right around the corner. At some point, Ms. Carey explained to the CPIs that she even had a "power of attorney" over L.P. However, the CPIs never asked to see the power of attorney and never

[9] D.A.V.I.D. refers to the Driver and Vehicle Identification Database which all CPIs have the right and obligation to access in order to obtain a subject's driver's license photo.

[10] There was dispute during the hearing as to whether Ms. Carey was shouting out using Ms. Parker's name or not; however, upon a review of the evidence, it seems more probable than not that Ms. Carey did, in fact, call out to "Ashley" and that a reasonable and prudent investigator would have heard a different name used than who they thought was in the house, sparking concern as to the actual identity of the subject inside.

verified what power it was assigning to Ms. Carey. Based on the belief that Ms. Parker was not home and L.P. was safe as Ms. Carey frequently spent time with her, the CPIs erroneously found no pending or impending danger to L.P. The CPIs failed to memorialize any kind of safety provisions for L.P. in a safety plan,[11] and left the house, leaving L.P. in present or impending danger under her mother's care.

Attempted Murder of L.P.

The following morning, on June 27, 2015, while L.P.'s grandparents were running an errand to the store, Ms. Parker attempted to murder L.P. by stabbing her 14 times and trying to drown her in the toilet. Upon returning from their brief run to the store, Mr. and Mrs. Carey arrived to Ms. Parker's home to find the door locked. After pounding on the door and yelling for Ms. Parker and L.P., the Careys were let into the house by Ms. Parker. Upon entering the home they discovered L.P. wrapped in a pink blanket lying on the ground. The grandparents repeatedly asked L.P. to "come to them," to which L.P. responded, "I can't." Further, Ms. Parker then looked to the grandparents and also stated, "she can't." At that point the grandparents realized L.P. was bloody and injured and immediately called 911.

Subsequently, it was discovered that L.P. had been stabbed 14 times all over her body, primarily on the abdomen/trunk area but also all over her back, arms, and legs. Her intestines were "spilling out" of open wounds on her body and was in critical condition. According to testimony from the paramedic who reported to the scene, L.P. was soaking wet, her hair was wet, and she had two band aids on her wounds. The paramedic testified that, as he was assessing L.P.'s injuries, Ms. Parker came walking out from the back bedroom holding a large chef's knife and told the paramedic that L.P. had fallen on the knife. At this point, the paramedic was in fear for his own safety and did what he could to get himself and L.P. out of the house safely.

Ms. Parker was arrested and convicted for attempted homicide and aggravated child abuse with a weapon. She was sentenced to 40 years of incarceration followed by probation for the remainder of her life under the Florida Department of Corrections.

Mr. and Mrs. Carey legally adopted L.P. on March 30, 2016.

L.P. (now "L.C." after the adoption) is currently a 15-year old high school student who enjoys living with her adoptive parents (her grandparents). L.P. loves art and hopes to one day study marine biology. Unfortunately, L.P. has suffered and continues to suffer significant physical and psychological injuries following the heinous acts by her mother.

LITIGATION AND LEGISLATIVE HISTORY

This claim is based upon a jury verdict issued by a Sarasota County jury. The jury verdict was rendered on March 11, 2022, after a three-week long trial, and the court entered a Final Judgment in the amount of $28 million against DCF on April 7, 2022. The jury divided the recommended $28 million award as follows:

- $30,248.33 in past medical expenses;
- $14,002,766 in future medical expenses (reduced to present value);
- $1,500,000 in future loss of earning capacity;

[11] A safety plan protects a child when a parent is unavailable, unable, or unwilling to protect his or her child. A safety plan manages or controls the condition that results in a child being unsafe. Active safety management of a safety plan involves diligent monitoring activities by the child welfare professional to determine that the safety plan is working dependably to keep the child safe. Safety management includes timely modification of a safety plan as needed. A safety plan will remain in effect as long as a case remains open and the parent or guardian does not have the protective capacity necessary to protect the child from identified danger threats. A safety plan must be created with the consent of the parent or parents it seeks to protect the child from.

- $4,155,661.60 for the past pain and suffering; and
- $8,311,323.87 for the future for pain, suffering, disability, disfigurement, mental anguish, inconvenience, and loss of capacity for the enjoyment of life.

DCF filed a Notice of Appeal in the Second District Court of Appeals ("Second DCA") on May 2, 2022. The Second DCA *per curiam* affirmed[12] the trial court's decision on September 15, 2023; thus affirming and upholding the jury's verdict and the Final Judgment issued by the lower court.

This claim bill is being presented during the 2025 legislative session for the first time. A hearing was held by the House and Senate Special Masters, appointed by Speaker Perez and President Albritton, respectively, on January 31, 2025, in Tallahassee, Florida.

POSITIONS OF CLAIMANT AND RESPONDENT

Claimant's Position

Claimant alleges that she is entitled to the remaining amount of her Final Judgment ($27,800,000) as DCF has only paid its sovereign immunity cap ($200,000) toward the restitution awarded to her by the jury. Claimant argues that DCF was negligent in its investigation on June 26, 2015, and negligently left L.P. in the care and custody of her mother, Ms. Parker, who then stabbed her 14 times and attempted to drown her in the toilet. Claimant argues that DCF had a duty to protect L.P. from harm, breached that duty in a number of ways throughout the pre-commencement and initial contact investigation phases, and failed to identify present and impending danger to L.P., leaving her in the care of Ms. Parker. Claimant argues that such negligence was a legal cause of the injuries sustained by L.P.

Respondent's Position

DCF acknowledges that the stabbing of L.P. by Ms. Parker is nothing short of tragic. However, DCF argues that its employees did not violate any statutes, rules, or policies and procedures in conducting its investigation on June 26, 2015 and therefore, did not breach any duty it may have owed to L.P. DCF further argues that none of the information gathered before or after the stabbing incident occurred could have put DCF in any position to find present or impending danger and implement a safety plan in violation of Ms. Parker's rights to parent her child free from governmental interference. Any alleged instability Ms. Parker may have had at no time impacted the safety of L.P. and the mere existence of mental instability alone cannot justify DCF's intrusion upon Ms. Parker's rights to her child. Further, even if DCF failed to comply with its statutes, rules, and policies pertaining to child protective investigations, there is no evidence to support that such would have been a direct and proximate cause of the injuries and damages sustained by L.P.

CONCLUSIONS OF LAW

Negligence

Negligence in General

"Negligence" is the failure to use reasonable care, which is the care that a reasonably careful person would use under like circumstances.[13] Negligence is doing something that a reasonably careful person would not do under like circumstances or failing to do something that a reasonably careful person would do under like circumstances.[14] It is important to note, that

[12] A "per curiam affirmed decision" means that the judges reviewed the case and determined that there was no reversible error. Thus, they affirmed the lower court's decision. The court found that it was not necessary to write an explanation other than the decision that there was not reversible error.
[13] 38 Fla. Jur 2d Negligence s. 1.
[14] Fla. Standard Jury Instruction 401.4 at 57.

negligence, as applied to this case, is not whether there was a deviation from or failure to follow DCF procedures and Florida law, but rather, whether DCF acted reasonably.

Regardless of whether there is a jury verdict or settlement agreement, each claim bill is reviewed *de novo* in light of the elements of negligence. The fundamental elements of an action for negligence, which a claimant must establish, are:

- Duty: The existence of a duty recognized by law requiring the respondent to conform to a certain standard of conduct for the protection of others including the claimant.
- Breach: A failure on the part of the respondent to perform that duty.
- Causation: An injury or damage to the claimant proximately caused by the respondent.
- Damages.

The standard evidentiary burden in a negligence case is proof by "the greater weight of the evidence." Florida law set forth in Standard Jury Instruction 401.3 defines "greater weight of the evidence" as the more persuasive and convincing force and effect of the entire evidence in the case. Further, in a claim for negligence, the Claimant is not required to prove the violation of any particular statute, policy, training material, or code, rather, must prove the four elements of common law negligence. While violations of specific codes or statutes are evidence of negligence, such violations are not, themselves, conclusive evidence of negligence.[15]

Respondeat Superior

Under the common law *respondeat superior* doctrine, an employer is liable for the negligence of its employee when the:

- Individual was an employee when the negligence occurred;
- Employee was acting within the course and scope of his or her employment; and
- Employee's activities were of a benefit to the employer.[16]

For conduct to be considered within the course and scope of the employee's employment, such conduct must have:

- Been of the kind for which the employee was employed to perform;
- Occurred within the time and space limits of his employment; and
- Been due at least in part to a purpose serving the employment.[17]

Duty

DCF has a statutory and common law duty to reasonably investigate, supervise, and protect the welfare of children in the state. The mission and purpose of DCF, as provided in s. 20.19, F.S., is to work in partnership with local communities to protect the vulnerable, promote strong economically self-sufficient families, and advance personal and family recovery and resiliency. To this end, DCF must develop a strategic plan for fulfilling its mission and establish a set of measurable goals, objectives, performance standards, and quality assurance requirements to ensure that DCF is accountable to the people of Florida.[18] Further, it is the goal of DCF to protect the best interest of children by ensuring that, first and foremost, children are protected from abuse and neglect.[19]

Further, chapter 39 of the Florida Statutes requires DCF to establish, maintain, and operate a central abuse hotline capable of receiving all reports of known or suspected child abuse, abandonment, or neglect. Upon receiving an abuse report, DCF has a duty to properly

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[15] Fla. Standard Jury Instruction 401.9 at 63, *Violation of Statute, Ordinance or Regulation as Evidence of Negligence*.
[16] *Iglesia Cristiana La Casa Del Senor, Inc. v. L.M.*, 783 So. 2d 353 (Fla. 3d DCA 2001).
[17] *Spencer v. Assurance Co. of Am.*, 39 F.3d 1146 (11th Cir. 1994) (applying Florida law).
[18] 57 Fl. Jur. 2d. *Welfare* §7 (August 2024) *citing to* s. 20.19(1)(b), F.S.
[19] S. 409. 986(2)(a), F.S.

investigate the allegations. The hotline must be available twenty-four hours a day, seven days a week.[20] Thus, DCF has a statutory duty to protect children under their care and children with whom reports of abuse, abandonment, or neglect have been made. The hotline must enable DCF to:

- Accept reports for investigation when there is reasonable cause to suspect that a child has been or is being abused or neglected or has been abandoned.
- Determine whether the allegations made by the reporter require an immediate or a 24-hour response.
- Immediately identify and locate previous reports or cases of child abuse, abandonment, or neglect through the use of an automated tracking system.
- Track critical steps in the investigative process to ensure compliance with all requirements for any report of abuse, abandonment, or neglect.
- When appropriate, refer reporters who do not allege abuse, abandonment, or neglect to other organizations or sources that may better resolve the reporter's concerns.
- Serve as a resource for the valuation, management, and planning of preventative and remedial services for children who have been abused, abandoned, or neglected.
- Initiate and enter into agreements with other states for the purposes of gathering and sharing information contained in reports on child maltreatment to further enhance programs for the protection of children.
- Promote public awareness of the central abuse hotline through community-based partner organizations and public service campaigns.[21]

Section 39.203, F.S., provides civil and criminal immunity from liability in all cases of child abuse, abandonment, or neglect to any person, official, or institution participating in good faith in any act authorized or required under chapter 39, or reporting in good faith any instance of child abuse, abandonment, or neglect to DCF or law enforcement.[22] However, it has been well established through case law that the immunity provided under section 39.203, F.S., applies to those reporting suspected maltreatment, and does not apply, in general, to DCF, the agency charged with protecting children in the state of Florida.[23] [24]

Additionally, court precedent has established that the actions of DCF and its employees and agents are "operational level" activities which are not shielded by immunity.[25] As such, the

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[20] S. 39.101(1), F.S.
[21] S. 39.101(1)(b), F.S.
[22] S. 39.203(1), F.S.
[23] *See Urqhuat v. Helmich*, 947 So. 2d 539, 541 (Fla. 1st DCA 2006), providing that the good faith immunity afforded by section 39.203, F.S., applies broadly to any person who makes a report of child abuse and that the Legislature purposefully left room for the possibility that the reporting procedure might be used for an improper purpose. As such, if an unfounded report is made, the parent of the child has some legal recourse to assert a claim against the reporter and the person making the report would be immune from liability only if the report was made in good faith. *See also Ross v. Blank*, 958 So. 2d 437 (Fla. 4th DCA 2007), which provides further discussion of *Urqhuat* and the distinction between the mandatory reporting requirement of doctors and other professionals under s. 39.201, F.S., and the grant of immunity provided to those who make a report by s. 39.203, F.S.
[24] *See Floyd v. Department of Children and Families*, 855 So. 2d 204 (Fla. 1st DCA 2003), in which the court held that statutory immunity from liability for good faith participation in child protection actions or reporting suspected abuse, abandonment, or neglect did not apply to protect DCF from liability for wrongful death for alleged negligence in returning the child to the mother despite reports of abuse and knowledge that the mother's live-in boyfriend, who subsequently murdered the child, had a history of abuse.
[25] *Department of Health and Rehabilitative Services v. Yamuni*, 529 So. 2d 258, 259 (Fla. 1988), *citing to Commercial Carrier Corp. v. Indian River County*, 371 So .2d 1010 (Fla. 1979) for an extensive discussion of the broad scope of the legislative waiver of sovereign immunity under s. 768.28, F.S., and the exception to such waiver for "policy-making, planning or judgmental government functions." Under *Commercial Carrier*, policy-making, planning, or judgmental activities by a state agency may be immune from tort liability even with the state's waiver of sovereign immunity. However, if the actions in question do not rise to the basic level of policy making, and are, rather, operational level activities, there is a waiver of

state's waiver of sovereign immunity in tort actions against the agency pursuant to s. 768.28, F.S., applies to the present matter and DCF is not afforded complete immunity for negligent actions.

It can be argued that DCF had a number of inherent and legal duties it was responsible for during the pre-commencement and initial home visit phases, including a duty to:

- Follow the law;
- Consider the "totality of the circumstances;"
- Check for prior DCF reports and records concerning the mother;
- Check for and learn the contents of recent local law enforcement "call-outs" or contact with the mother;
- Speak to the mandatory reporter, which in this case was the Sarasota Police Officer who called the hotline; and
- Learn of additional available mental health information as to the mother.
- Identify everyone in the home during the visit, especially the subject of the investigation;
- Call the police for help in doing their job as needed;
- Have a face-to-face meeting with the mother, Ms. Parker, to properly assess her for "Present" or "Impending Danger" threats to L.P.;
- Consider all circumstances, prior DCF reports, police call-outs, and other similar contributing and informative sources for the purpose of properly making a determination of the existence of present or impending danger posed by Ms. Parker to L.P.;
- Determine the existence of a present and impending danger posed by Ms. Parker to the safety and well-being of L.P.; and
- Implement a safety plan for the protection of L.P. due to her mother being a present and impending danger to L.P.'s safety and well-being.

As detailed above in the "Findings of Fact," the DCF CPIs failed to assess the situation and threats in a reasonable manner, resulting in L.P. being left in Ms. Parker's care with no safety plan, despite her apparent troubling mental health, her refusal to comply with the CPI's investigation, her concealment of her actual identity, and the vulnerable age of L.P. at the time of the incident. DCF had a duty, initiated by the call to the abuse hotline, to wholly investigate and assess the situation to protect L.P. from harm.

Breach & Causation

Legal Cause

Negligence is a legal cause of loss, injury, or damage if it directly and in natural and continuous sequence produces 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.[26]

Concurring Cause

In order to be regarded as a legal cause of loss, injury, or damage negligence need not be the only cause.[27] Negligence may be a legal cause of loss, injury, or damage even though it operates in combination with the act of another, some natural cause, or some other cause if the negligence contributes substantially to producing such loss, injury, or damage.[28]

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sovereign immunity and the agency may be liable in a tort claim. *See also Evangelical United Brethren Church v. State*, 67 Wash. 2d 246, 407 P. 2d 440 (1965) and *Johnson v. State*, 69 Cal. 2d 782 Cal.Rptr. 240, 447 P. 2d 352 (1968).

[26] Restatement (Second) of Torts s. 431 (1965).

[27] *Goldschmidt v. Holman*, 571 So. 2d 422 (Fla. 1990).

[28] *Hernandez v. State Farm Fire and Cas. Co.*, 700 So. 2d 451, 453 (Fla. 4th DCA 1997), *citing to Little v. Miller*, 311 So. 2d 116 (Fla. 4th DCA 1975).

Intervening Cause

In order to be regarded as a legal cause of loss, injury, or damage, negligence need not be its only cause. Negligence may also be a legal cause of loss, injury, or damage even though it operates in combination with the act of another, some natural cause, or some other cause occurring after the negligence occurs if such other cause was itself reasonably foreseeable and the negligence contributes substantially to producing such loss, injury, or damage or the resulting loss, injury, or damage was a reasonably foreseeable consequence of the negligence and the negligence contributes substantially to producing it.[29]

Specific Breaches that Occurred

Duty to Assess the Totality of the Evidence

The totality of the evidence reviewed by the Special Master illustrates a number of failures by DCF and its CPIs throughout the pre-commencement and home visit phases of the investigation into Ms. Parker. The DCF CPIs responsible for this investigation did not act reasonably under the circumstances.

Further, based upon the evidence presented, the CPIs failed to make contact with the reporting police officers (SPD Officers Tschetter and Kennedy) and failed to obtain the police call-out history relating to Ms. Parker and her residence from March 9, 2015 through June 25, 2015. Thus, DCF was not able to consider the totality of the circumstances in making a determination regarding whether present or impending danger existed.

Duty to Follow the Law

A reasonable and prudent CPI knows and understands that he or she has the duty to follow the law. CPI Lopez, in her trial testimony, admitted that she did not even fully know the laws she was to be following when conducting this investigation.[30]

DCF CPI Tucker arrived at Ms. Parker's home at 7:43 p.m. The call to the Sarasota office came in at 4:31 p.m., and, as the case was designated as requiring an immediate response, CPI Tucker was required to arrive at the home as soon as possible, but no later than 2 hours after the call came in (that would have been at 6:31 p.m.). Thus, CPI Tucker was more than an hour late to make initial contact as required by the Florida Administrative Code.

Throughout the trial, DCF Senior CPI Tucker contended that the response time for an immediate response case was four hours. However, evidence presented confirmed that the law had changed in December of 2014 when the applicable administrative code was revised. All DCF staff, including CPIs, were notified of the change from a 4-hour response time to a 2-hour response time. Despite being presented with evidence of the actual laws CPIs were required to follow, CPIs Tucker and Lopez maintained that the response time requirement was four hours and that is what they had always been told to abide by in the past. The CPIs were clearly ignorant of the laws they were required to follow in conducting their investigations. Whether the ignorance of the law was due to improper training by DCF or the individual failure of the CPIs, there was clearly a breach of the CPIs' duty to know and follow the applicable laws.

Duty to Review Prior DCF Records and Reports

Additionally, DCF CPIs either failed to check for prior DCF reports and records involving Ms. Parker or simply ignored the evidence contained therein during the pre-commencement phase

[29] 6 Fla. Prac., Personal Injury & Wrongful Death Actions s. 3:6, *citing to Tampa Elec. Co. v. Jones*, 138 Fla. 746, 190 So. 26, 27 (1939).
[30] Trial Testimony of CPI Lopez at 816.

of the investigation.[31] Evidence presented identified four prior incidents in which Ms. Parker dropped L.P. as a small child, with one of those incidents resulting in a trip to the hospital for a CT scan. DCF argued that it had no proof of prior injury to L.P. by Ms. Parker, however, a review of the DCF records clearly suggests otherwise.

Further, there was a DCF report regarding a 19-month old foster child in Ms. Parker's care (prior to L.P.'s birth) who's chest was mysteriously burned while under her care. Ms. Parker told investigators that the child did it to herself by getting a hold of a container of IcyHot; however, evidence suggests the burn was caused by a space heater. This incident resulted in a felony child endangerment conviction for Ms. Parker.

Additionally, DCF records contained an allegation of a foster child under Ms. Parker's care who fell down stairs resulting in injuries. Notably, a prior DCF report included the following statement written by another CPI:

> *Coupled with the erratic behavior of the mother, it is feared that the child (L.P.) may at some later date be harmed as a result of this erratic behavior. Reasonable preventative measure should protect this child from further harm, mom has demonstrated the inability to be reasonable.*

Prior DCF reports also included comments illustrating deep concerns about Ms. Parker's undiagnosed mental health issues and erratic behavior which raised questions about her ability to care for a child. Specifically, a CPI who previously investigated Ms. Parker testified that his interactions with her illustrated clear evidence of foreseeability that Ms. Parker could harm or kill L.P. if DCF did not get involved and impose safety measures.

Further, from a review of the DCF reports, it is clear that Ms. Parker had significant contacts with the department. What is more concerning is that Ms. Parker had twice previously had a child removed from her care by a judge as well as at least two separate incidents in which a DCF CPI noted that the risk assessed with the respective investigation was "high."

Duty to Review Police Call-Outs

While there was some dispute as to whether DCF CPIs attempted to call Officers Tschetter and Kennedy, the truth of the matter is that no actual contact was made with the officers and no criminal history, call-out history, or additional details were obtained about Ms. Parker's interactions with law enforcement by the CPIs. Even if the CPIs did "leave a voicemail" for the officers, there was still more they could have done to attempt to make actual contact with the officers or, at the very least, request law enforcement records relative to Ms. Parker. No attempt to obtain such records was made until after Ms. Parker attempted to murder L.P., at which point, the SPD provided the requested records to DCF within 52 minutes of the request being made.

Of significant note, in the four months leading up to the attempted murder of L.P., the SPD received 8 different calls relating to Ms. Parker, all of which were essentially unknown to the CPIs because they failed to contact the SPD or the officers who responded on June 26, 2015. Further, between January 30, 2007 and June 26, 2015 (the night before the attempted murder), the SPD was dispatched to Ms. Parker's residence at least 21 times.

In summary, had CPIs Tucker and Lopez called SPD and Officers Tschetter and Kennedy as they were required to do, they would have had actual knowledge of concerning behaviors, including incidents involving Ms. Parker:

- Being recently Baker Acted;

[31] Pursuant to DCF training materials, DCF has, among other common law duties, the duty to check for prior DCF reports and records to assess for anything of possible concern as part of the totality of the circumstances determination.

- Making false reports and lying to the police;
- Making bizarre claims the SPD was trying to poison the air in her air conditioner;
- Reporting imaginary threats made against her by invisible and non-existent people holding a gun to her head;
- Falsely alleging that the SPD was threatening her, tapping her phone, had cut her brake lines to cause an accident;
- Claiming that a person named "Mooncheese" was going to kidnap her and her child;
- Leaving another suicide note a mere months before she attempted to murder L.P.;
- Falsely claiming that L.P. was being molested and she had video proof (which did not exist);
- Claiming that SPD was trying to have her kidnapped and make the kidnapping look like it was a suicide;
- Alleging that the KKK was inside of the SPD and had ordered Ms. Parker dead;
- Alleging that the "feds" were watching her; and
- Making a number of other delusional claims and allegations which illustrated a severe mental health concern.

Duty to Speak to the Mandatory Reporter

Pursuant to s. 39.301(6), F.S., if a report was received by a mandatory reporter under s. 39.201(1)(a)2., F.S., the CPI must provide his or her contact information to the reporter within 24 hours after being assigned to the investigation. Further, the CPI must advise the reporter that he or she may provide a written summary of the report made to the central abuse hotline to the investigator to be included as part of the electronic child welfare case file.

Whether there was a breach in the duty to contact the mandatory reporter and provide the required information is somewhat unclear. In this case, the attempted murder of L.P. occurred the morning after CPIs were assigned the investigation (and statute requires CPI communication to the mandatory reporter within 24 hours). However, from a review of the totality of the evidence, no additional attempts were made by the CPIs to contact the mandatory reporters prior to the attempted murder and, concurrently, the 24-hour mark.

Duty to Learn of Additional Mental Health Information

From a review of the records, it is apparent that Ms. Parker had significant mental health issues, including issues with seeing imaginary people, paranoia, and clear breaks with reality that indicated possible mental illness; Ms. Parker had even had a history of being Baker Acted for mental health concerns. Further, a review of the prior DCF records clearly established a history of lying to investigators, something that should have been a red flag at the onset of the investigation in question.

Further, according to testimony from another investigator during the trial on this matter, a parent's mental illness alone coupled with evidence of suicidal intention are reason enough to remove a child from its parent and a potentially suicidal parent with mental illness is a "present danger."[32]

Duty to Identify Everyone in the Home and Have a Face-to-Face Meeting with the Subject Parent

Pursuant to DCF policies and s. 39.301(9)(a), F.S., DCF must perform the following child protective investigation activities to determine child safety:

- Conduct a review of all relevant, available information specific to the child, family, and alleged maltreatment; family child welfare history; local, state, and federal criminal records checks; and requests for law enforcement assistance provided by the abuse

[32] Munoz at 506, 510.

hotline.
- Conduct face-to-face interviews with the child; other siblings, if any; and the parents, legal custodians, or caregivers.
- Assess the child's residence, including a determination of the composition of the family and household, including the name, address, date of birth, social security number, sex, and race of each child named in the report; any siblings or other children in the same household or in the care of the same adults; the parents, legal custodians, or caregivers; and any other adults in the same household.
- Determine whether there is any indication that any child in the family or household has been abused, abandoned, or neglected; the nature and extent of present or prior injuries, abuse, or neglect, and any evidence thereof; and a determination as to the person or persons apparently responsible for the abuse, abandonment, or neglect, including the name, address, date of birth, social security number, sex, and race of each such person.
- Complete assessment of immediate child safety for each child based on available records, interviews, and observations with all identified persons named and appropriate collateral contacts, which may include other professionals, and continually assess the child's safety throughout the investigation.
- Document the present and impending dangers to each child based on the identification of inadequate protective capacity through utilization of a standardized safety assessment instrument.

The CPIs, having actual knowledge from their review of prior DCF reports that Ms. Parker had a history of lying to the DCF and law enforcement, put full faith in her statement that she was "Valencia" and trusted that Ms. Parker was not present at the home.

By CPI Lopez's own testimony, she recalled that Ms. Parker's DCF history in the FSFN system included a number of reports stating that she has a history of:
- Being uncooperative;
- Lying to investigators;
- Erratic behavior;
- Behavior so disturbing that her prior case had been staffed in the past on a number of occasions, including staffed with lawyers and DCF leadership;
- Her prior case being elevated to "red flag staffing;"
- Behavior evidencing serious questions about her mental health; and
- Felony abuse or child endangerment.

Despite having allegedly reviewed all of the prior DCF reports involving Ms. Parker, CPI Lopez still took no action to verify the identity of the subject at the home. DCF failed to identify the subject of its investigation and left a vulnerable 6-year old child in a home despite never verifying the identity of the woman present in the home and despite never discovering the whereabouts of Ms. Parker (as they testified they believed Ms. Parker was not present at the house and the woman inside was Ms. "Valencia Dubois").

Duty to Assess the Possible Present or Impending Danger Threat to the Child

Pursuant to DCF policies and s. 39.301(9)(a), F.S., and as further explained above, DCF must perform certain specified child protective investigation activities to determine child safety.

As noted previously in this report, a reasonable person would have, more likely than not, had significant concerns for the safety of the child requiring a safety plan or some precautions to be taken. However, the CPIs in this case simply left the house with no concern, clearly ignoring a disturbing amount of "red flags" of concern. During the hearing on the matter, testimony from other CPIs was offered through which they confirmed that, if they had been the CPIs to investigate this case, they would not have just left the home and would have determined some level of threat and danger to be present.

Duty to Implement a Safety Plan

Pursuant to s. 39.301(9)(a)(6), F.S., if present or impending danger is identified, the CPI must implement a safety plan or take the child into custody. If present danger is identified and the child is not removed, the CPI must create and implement a safety plan before leaving the home or the location where there is present danger. If impending danger is identified, the CPI shall create and implement a safety plan as soon as necessary to protect the safety of the child. The CPI may modify the safety plan if he or she identifies additional impending danger.

It is worth noting that, despite the number of duties DCF has when it comes to conducting an investigation, those duties are not necessarily expected to be completed in full prior to the initial home visit to assess the situation. DCF CPIs must prepare and act quickly to ensure the safety of the child or children at issue in response to an allegation of abuse, abandonment, or neglect made to the hotline. However, DCF CPIs in this case, did not even try to accomplish any of the due diligence a reasonable and prudent investigator would prior to arriving at the residence of the alleged maltreatment. It would seem clearly reasonable and prudent to collect information such as police call-outs, DCF history, and mental health concerns and history prior to making contact with Ms. Parker, not only to be best equipped to protect the safety of L.P., but to ensure the personal safety of the CPIs themselves. It would be prudent, as a CPI, to know the level of danger about to be encountered for personal safety as well as the safety of others.

Due to the number of failures by DCF CPIs during the pre-commencement and home visit phases of the investigation, CPIs Lopez and Tucker failed to identify the present and/or impending danger that Ms. Parker posed to L.P. Such a finding of a present or impending danger would have resulted in the creation of a safety plan by DCF. It is clear that DCF breached its duty to protect L.P. during this investigation.

It is not enough for a finding of negligence that DCF breached its duties to L.P. Rather, the evidence must show that DCF's breach was a cause of the damages caused to L.P. The element of causation is the trickiest and most problematic of the four elements in this matter. After all, Claimant is attributing a violent and heinous act committed by L.P. to DCF through negligence. It should be emphasized that causation is not an easy burden to bear, especially when the "bad act" was clearly committed by Ms. Parker, and neither DCF nor its CPIs were the ones to stab L.P. fourteen times leaving her disemboweled and on death's doorstep.

Florida law and legal case history have clearly established that DCF has been statutorily placed in a significant position with a tremendous responsibility to keep the children of Florida safe. The Special Master does not take DCF's responsibilities lightly, and acknowledges the heightened position the department has been placed in. However, DCF has been tasked with the great responsibility of protecting the children of Florida from abuse, abandonment, and neglect, and the imposition of such a great responsibility does not lessen the weight given to its actions and inactions. DCF must hold itself and its investigators to the highest of standards and ensure that all reasonable and prudent steps are taken to ensure the safety of the children in the state.

Thus, the issue of causation cannot simply be dismissed because the mother was the bad actor. Rather, the situation must be assessed to determine whether DCF's actions or inactions were a contributing legal cause of L.P.'s horrific injuries. In the instant case, DCF clearly fell short of its basic duties and responsibilities. Not only did DCF's negligent investigation place L.P. in serious harm, but could have placed CPIs Lopez and Tucker in an incredibly dangerous situation as well. DCF's failures to act reasonably were a legal cause to L.P.s injuries.

Had present or impending danger been identified, as it seems should have been clear to a reasonable person, then a safety plan would have been created with safeguards and mechanisms in place to protect L.P. from her mother. Further, DCF has argued that even if a safety plan had been created, the mother would have had to agree to it and sign off on it, which

it hypothesizes that she would have refused to do. However, when looking at the situation and the totality of the evidence, a refusal by Ms. Parker to consent to a safety plan would have been yet another "red flag" to the CPIs signaling the need for more drastic action; that is, possibly sheltering L.P. until they could verify her safety under Ms. Parker's care. None of these things happened. DCF CPIs left the home, left L.P. in the care of a mentally unstable and likely suicidal mother with zero precautions or safety mechanisms in place. Subsequently, in a matter of hours after DCF CPIs left the home, Ms. Parker stabbed L.P. 14 times, nearly killing her, and imposing a lifetime of psychological and physical struggles upon L.P.

Damages

There is no question that L.P. suffered a significant and incomprehensible tragedy when Ms. Parker attempted to murder her, stabbing her 14 times at the age of 6. L.P. has clearly suffered, both physically and psychologically, the effects from that incident. L.P. will likely have to undergo additional medical procedures and therapies in the future to continue to manage the injuries she sustained in 2015.

The evidence presented at the Special Master hearing, as at trial, was that due to DCF's breach of duties, L.P., was caused significant injuries and damages.[33]

Doctors Al-Rawi and Jaicks testified regarding the immediate medical and surgical care they provided to L.P. She had life-threatening injuries that required immediate emergency surgery at Sarasota Memorial Hospital to address the 14 stab wounds inflicted upon her by her mother as well as the evisceration of her bowels. L.P. was subsequently transported by medical helicopter to John Hopkins All Children's Hospital in St. Petersburg for further evaluation and care.

Evidence was presented by Dr. Michael Shahnasarian, a licensed psychologist and expert in the fields of: (1) vocational assessment and rehabilitation; and (2) life care planning. DCF stipulated to Dr. Shahnasarian's qualifications as an expert in his fields. Dr. Shahnasarian authored a vocational assessment and rehabilitation report which outlined the impact that the events have had on L.P.'s life and the anticipated effects that they will continue to have on the rest of her life. Dr. Shahnasarian testified that as a result of the incident, L.P. experienced significant learning challenges in school, including the need to repeat third grade; poor performance on standardized testing; and the necessity for an Individualized Education Plan which set forth a number of accommodations that L.P. required in order to attempt to meet basic educational benchmarks.

Dr. Shahnasarian also authored a detailed Life Care Plan, which is comprised of data that Dr. Shahnasarian obtained from numerous sources, including medical records, educational records, and discussions with L.P.'s doctors, counselors, therapists, and school administrators.

He opined that there is a very low likelihood that L.P. will be able to live independently when she becomes an adult, and given the advanced age of her adoptive parents,[34] once both of her adoptive parents have passed away she will be left without necessary support. This would require the need for some attendant care and/or companion services, and he provided three different options for anticipated attendant care, commenting that the most likely option would be a minimum of Attendant Care with Companion Services to assist L.P. with the basic functions of eventual adulthood on a periodic basis.

Claimant's expert evaluated the economic present value, as of the time of the civil jury trial in

[33] DCF did not present any contrary evidence either at trial or in the Special Master Hearing as it related to damages.

[34] L.P.'s adoptive parents, her biological grandmother and her grandmother's husband, are retired and in their late 60s and 70s. Dr. Shahnasarian testified that L.P. will require assistance and companionship for the remainder of her life. Due to the Careys current age, it is unlikely that they will be available to assist L.P. as she gets older.

this case, of Dr. Shahnasarian's Life Care Plan recommendations to be between $7,932,170 and $14,002,766.

The jury awarded the full value of the past medical bills ($30,248.33), the full value of Dr. Shahnasarian's Life Care Plan recommendations ($14,002,766), and assessed her future earning capacity diminishment at $1,500,000.

The evidence presented was that L.P. had to undergo life-saving surgery, will endure ongoing abdominal pain and the development of internal adhesions as she grows requiring future surgeries, ongoing psychiatric and psychological care, including inpatient care, past and future ongoing pain, suffering, disability, disfigurement, inconvenience, mental anguish and loss of capacity to enjoy life. These non-economic damages comprised the remainder of the jury's award for total of all damages of $28,000,000.

While in no way diminishing the tragic incident or its lasting impact on L.P.'s life, a discussion of damages would not be complete without assessing the amount sought in terms of reasonability. Claimant's life has been tragically and irreversibly altered by the stabbing incident, and now she requires medical and psychological treatments and services. However, in light of the amounts the Legislature has awarded in similarly-situated claimants in the recent past, the Legislature may determine that a smaller award is reasonable in this case.

AMOUNT OF CLAIM BILL

This claim bill is based upon a $28 million award issued by a Sarasota jury for the benefit of L.P. To date, Claimant has received the sovereign immunity limit of $200,000 from DCF; thus, Claimant is seeking the remaining $27,800,000 owed under the Final Judgment. There are no other collateral suits or settlements. The $200,000 received by Claimant from DCF has been applied to the legal case costs which total $223,506.52; thus, claimant has an outstanding balance for litigation costs owed to her attorneys in the amount of $23,506.52.

ATTORNEY AND LOBBYING FEES

If this claim bill passes, Claimant attests that attorney fees will not exceed 25% of the total amount awarded ($7 million) and lobbying fees will not exceed 5% of the total amount awarded ($1.4 million). Additionally, Claimant attests that appellate counsel fees will not exceed 5% of the total amount awarded ($1.4 million).

Outstanding costs, as sworn to by the Claimant, are $9,184.10. Additionally, there are outstanding liens in this matter that will need to be satisfied should the bill pass and Claimant receive payment. The outstanding liens include:

- $19,378.77 owed to Optum Subrogation Services.[35]
- $10,869.56 owed to Equian.[36]

CONCLUSION AND RECOMMENDATION

While this case was riddled with points in the investigation where DCF failed to act reasonably, there were three primary failures that were the most glaring:

- The failure to obtain necessary and insightful police records during the pre-commencement phase and speak with the officers that made the report to the hotline;
- The failure to identify the subject parent, Ms. Parker, and the failure to verify the identity she provided to the CPIs; and
- The failure to, considering the totality of the circumstances, identify present or impending

[35] Optum Subrogation Services is a third-party administrator for Simply Healthcare Plans, Inc., Amerigroup Community Care d/b/a Simply Healthcare, and Clear Health Alliance.
[36] Equian is a third-party administrator for Medicaid/WellCare.

danger and attempt to create a safety plan for the protection of L.P.

DCF argued that a safety plan would not have impacted the unfortunate outcome, but it is difficult to believe that statement knowing that the CPIs did not even attempt to create and implement a safety plan. DCF argued that Ms. Parker would not have consented to and complied with a safety plan, but the CPIs did not even put forth the effort required to identify the mom, who was the subject of the abuse report call. Thus, it is impossible to know whether she would have refused participation in such a safety plan. Additionally, had DCF attempted to create and implement a safety plan, it would have given CPIs the opportunity to rectify their failure to identify the mother and would have given the opportunity to see if she would have consented to a safety plan. Had she been presented with the request for a safety plan and still refused, that clearly would have been yet another “red flag” to the CPIs, further strengthening the knowledge DCF already possessed regarding the mother’s history of lying to the department, being uncooperative, and mental health concerns.

It is the opinion of the Special Master that such a refusal and associated “red flags” would more likely than not have escalated the level of concern for L.P., possibly triggering the need to shelter L.P. until more investigation should be conducted and her safety could be ensured.

Based on the evidence presented, I recommend that CS/HB 6511 be reported FAVORABLY.

However, in light of the amounts the Legislature has awarded in similarly-situated claimants in the recent past, the Legislature may determine that a smaller award is reasonable in this case.

Respectfully submitted,

SARAH R. MATHEWS

House Special Master