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 6531 - Representative Brackett
Relief/H.H./Department of Children and Families

SUMMARY

This is a contested claim for $14,926,640 by H.H., a minor (hereinafter referred to as "H.H." or "Claimant") based on a jury verdict against the Florida Department of Children and Families ("DCF") for injuries and damages sustained due to 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 abuse reports called into the state's child abuse hotline. DCF closed one investigation, and while another investigation was open and pending, H.H. arrived to the hospital with catastrophic, life-threatening injuries sustained from abuse and torture by her mother and step-father.

FINDINGS OF FACT

Background

H.H. is a female who was born in November of 2015. H.H. has an older brother, C.H.[1], who suffered a birth injury and is completely disabled, requiring 24/7 care. H.H. lived with her brother, mother Amber Dudney ("Dudney"), and step-father, Harold Hall ("Hall") in Oak Hill, Florida. Dudney and Hall were married on April 1, 2017, after dating for only three months. Neither H.H. nor C.H. attended daycare and were not very "visible" to the community as they remained in the home on a daily basis. C.H. was slightly more "visible" as he attended doctor appointments on an occasional basis with Dudney.

Harold Hall, who was a caregiver to H.H. and C.H., has a decade-long significant and dangerous criminal history including two prior periods of incarceration and being found guilty of:

- Multiple drug convictions, including the possession of marijuana, paraphernalia, and the

[1] C.H. was completely immobile, requiring 24/7 support and use of a wheelchair and other medical devices, was on a ventilator to assist with breathing, and was non-communicative. Pursuant to a trust settlement resulting from C.H.'s birth injuries, Dudney received regular trust payments for the care of C.H.

manufacture of cannabis;
- Burglary of a dwelling (multiple times);
- Possession of cocaine;
- Fleeing or attempting to elude law enforcement (multiple times);
- Possession of a firearm by a convicted felon;
- Resisting arrest with violence (sentenced to 48 months in prison);
- Driving with a suspended license (sentenced to 192 days in jail);
- Battery on a law enforcement officer (sentenced to 48 months in prison);
- Escape (sentenced to 48 months in prison);
- Burglary of a dwelling or structure causing more than $1,000 in damage (sentenced to 25 years in prison);
- Criminal mischief of $1,000 or more (sentenced to 15 years in prison);
- Resisting an officer without violence (sentenced to 5 years in prison); and
- Grand Theft over $100,000 (sentenced to 25 years in prison).

Prior to DCF's involvement, H.H. was a healthy, happy 18-month old child. She could walk, talk, play, and enjoyed watching cartoons and playing in the park, and loved dancing to music. H.H. and C.H had no prior history with DCF until the May 3, 2017 abuse report was made. Both Dudney and Hall have had a history with DCF.

DCF Involvement and Investigations

First Abuse Hotline Report and DCF Case

On May 3, 2017, DCF received its first abuse hotline report relating to H.H. (18 months old) and C.H. The report alleged:
- Suspected substance abuse by the mother and step-father, mainly including marijuana;
- Concerns of neglect and inadequate supervision of the children;
- Suspicions that the mother and step-father were selling drugs (marijuana and "pills") out of the home;
- Reports of constant traffic into and out of the home;
- That Dudney and Hall had allowed a fugitive in the home;
- That the landlord had kicked the family out of the home; and
- That there was no furniture in the home and that C.H., who is severely handicapped, was sleeping on a mat on the floor.

Upon receiving the abuse allegation, Child Protective Investigator ("CPI") Kristi Boice was assigned as the investigator on the case. Once she was assigned the case, CPI Boice reviewed the initial abuse report taken by the staff at the abuse hotline, reviewed the allegations made, spoke with the reporter who made the call to the hotline, reviewed relevant criminal history, spoke with the probation officer of the day in relation to Hall's status and recent probation requirements, reviewed prior DCF reports, and made a visit to the Dudney/Hall home located at 429 Ward Drive in Oak Hill, Florida.

In speaking with the reporter who made the abuse allegation, CPI Boice learned that the reporter did not have "first-hand" knowledge of the home or the suspected drug use. Rather, the reporter had received that information from another party.

Six months before the first investigation, Hall had been released from prison where he served a term of 48 months and was on probation at the time of the investigation. CPI Boice contacted Hall's probation officer ("PO") and was told Hall's specific PO was out of the office. She then spoke to the "PO of the day" who looked up the records and informed CPI Boice that Hall was on probation and was compliant with the terms of his probation, drug-screens, check-ins, and that the assigned PO had made an unannounced visit to the home on April 25, 2017, and had no issues. The information from the PO of the day was solely based on the assigned PO's

notes; his comments were not based on any first-hand or verified information.

During the initial home visit to the Dudney/Hall home on May 3, 2017, Dudney and Hall admitted to CPI Boice that a fugitive from justice had been in their home but was no longer residing there. CPI Boice requested urinalysis ("UA") drug screenings from both Dudney and Hall; Dudney submitted to the UA and was positive for marijuana, while Hall refused the UA and instructed CPI Boice that she could get those results from his PO. CPI Boice observed both H.H. and C.H. during her visit.

On May 5, 2017, DCF completed a Child Present Danger Assessment for H.H. and found that "no present danger existed."

On July 2, 2017, a Senior CPI covering the case while the assigned supervisor was on vacation closed the first investigation, just hours before the 60-day mark.[2] The first case was closed out with no services put into place and no protective measures initiated. The second investigation remained open at this time. At the time this first investigation was closed, there had only been one visit to the home, which was the only time where DCF physically saw the children in person.

Second Abuse Hotline Report and DCF Case

On June 2, 2017, while the first investigation was still open and pending, DCF received a second abuse hotline report, again alleging substance abuse by the mother and step-father and concerns of neglect. Specifically, the second intake report alleged that in the previous month Dudney had left C.H. alone in the home while she took H.H. on an errand. This was significantly concerning as C.H. was young (3 years old at the time) and was severely disabled. C.H. was unable to eat or swallow anything, had a feeding tube, and needed to be constantly monitored due to his trach.[3] The abuse report also alleged that Dudney frequently left C.H. home alone and that such instance was not simply just a one-time occurrence. Further, the reporter alleged that Dudley constantly smoked marijuana inside the home and was not focused on the children's needs. Of significant concern was the reporter's allegation that Dudney had not taken C.H. out of the home in over 3 months.

Between June 3 and June 6, DCF CPIs made three unsuccessful attempts to conduct home visits as required by law. No contact was made with the children or Dudney or Hall. On June 3, around 8:30 a.m., CPI Boice spoke with an unidentified male neighbor who was outside while she was attempting to locate the family. The neighbor offered general remarks about the family based on what he had witnessed. CPI Boice did not ask this neighbor his name, his address, if he had ever actually met or spoken with the children or parents, or if he had ever observed the inside of the home.

On June 4, around 8:30 a.m., CPI Boice again attempted to conduct a home visit at the family's address. CPI Boice noted that no one was in the home and no noises were coming from inside the house. She spoke to an unidentified female who was walking her dog past the house while CPI Boice was outside. The neighbor made general statements about the family and told Boice she believed the family still lived in the house. The neighbor told CPI Boice that she had never been inside of the home, but that the mother seemed like a nice person. CPI Boice did not collect any identifying information, such as a name or telephone number, from this collateral witness.

On June 6, 2017, around 7:00 p.m., CPI Catiria Gonzalez, a CPI who was not assigned to the

[2] Pursuant to DCF policy, investigations should, whenever possible, be closed out within 60 days. However, DCF testified that, if needed, a case may remain open to conduct further investigation.
[3] The trach could collect a build-up of saliva that C.H. could choke on, and if that were to happen, it would need to immediately be suctioned out.

case, attempted, for a third-time, to conduct a home visit on behalf of CPI Boice.[4] CPI Gonzalez noted that the house appeared empty and there was no vehicle in the driveway. She did, however, witness a medium-sized dog in the front door. CPI Gonzalez then contacted Dudney by phone and informed her of the allegations made to the hotline. She told Dudney that there had been allegations made that C.H. had been left home alone and unattended. Dudney denied the allegations (via phone) and told CPI Gonzalez that she was out of the house looking for a new place to live as she was going to be moving out of her current residence. Again, the CPI failed to conduct a home visit, failed to have a face-to-face meeting with Dudney or Hall, failed to observe the children, did not interview the caregivers (Dudney and Hall), and did not enter and observe the home where the children were believed to be living.

On June 28, 2017, a third DCF CPI, Brandy Bucci, conducted an announced visit to a motel that the family was alleged to have been living in. CPI Boice had contacted Dudney on her cell phone earlier in the day and informed her that a visit would be conducted. Dudney told CPI Boice that she would not be home for two hours but could do the visit once she returned. Thus, when DCF finally had a face-to-face meeting with Dudney, it was during an announced visit that Dudney had ample time to prepare for. There was not a single unannounced home visit done in this second investigation. During this visit, CPI Bucci observed H.H. inside a playpen and C.H. laying on a Boppy pillow on the bed. She noted that the children appeared free of bruises indicative of abuse or neglect. Hall was not present during the visit and was allegedly at work. CPI Bucci noted that there was a delay in locating the family due to them moving to a new residence and documented that Dudney expressed frustration over the DCF reports.

Prior to conducting the visit at the motel, CPI Bucci failed to review any intake reports, as she was wrongly under the impression that she was just going to make a follow-up visit, not an initial visit. Thus, Bucci was unaware that Dudney had tested positive for marijuana during the first investigation and, therefore, didn't follow-up on that concern with an additional drug test. According to DCF records and testimony, CPI Bucci did not look in any cabinets while in the motel room, but merely glanced around without looking in depth at anything. Further, Bucci failed to physically assess H.H. for injuries beyond what was visible while she was in the playpen and fully clothed. CPI Bucci failed to make any collateral contacts and, essentially, conducted a shallow surface-level inspection which was unreasonable given that the visit was to conduct an initial visit, not a quick follow-up.

For a period of 25 days (from the date the intake call was made on June 3 to the time a CPI met the family at the motel on June 28), no investigation into the family was conducted. Further, for a period of 25 days from the time the second investigation was opened, DCF had no knowledge of the children's location or whether they were safe. Additionally, there was no evidence that DCF sought assistance from law enforcement in trying to locate the family; in fact, records from the DCF system show that no entries were made during the time between the third attempted home visit on June 6 and the visit to the motel on June 28.[5]

Abuse and Torture Resulting in Hospitalization of H.H.

On September 4, 2017, just over two months from the date the first investigation was closed, H.H. (21 months old) arrived at the hospital with life-threatening, catastrophic injuries. Four different reports were made to the DCF hotline alleging severe abuse and neglect of H.H. by her mother and step-father, reporting that H.H. presented to the hospital with injuries including:

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[4] It is important to note that at this point, the attempted home visits were on the new, and second, investigation. Thus, 3 days after receiving the abuse allegations, zero contact with the children and the family had been made.

[5] It is important to note that when conducting an investigation, CPIs must document everything; all actions, contact attempts, contacts to collateral sources, and all investigative activity must be documented in the DCF system. The DCF system includes timestamps which show, down to the minute, when an entry was made. DCF CPIs repeatedly testified to the importance of documenting the investigations by explaining the general theory that if it is not documented in the system, it did not happen.

- Not being alert or oriented;
- Bruises covering her head, trunk and abdomen area, and back in various stages of healing;
- Wounds resembling cigarette burns on various parts of her body including the soles of her feet and the backs of her knees;
- A severely infected mouth with a missing tooth and gums that had turned a grayish color;
- Bruises on her labia and concerns of possible sexual abuse;
- A buckle fracture;
- A severe brain bleed;
- Traumatic brain injury;
- Multiple areas of bleeding in her brain;
- Severe brain swelling due to repetitive abusive head trauma;
- Eye trauma; and
- Respiratory failure requiring a ventilator.

H.H. was placed into a medically-induced coma and transferred to Arnold Palmer Children's Hospital. Following her September 4th admission into the hospital, H.H. remained hospitalized for 109 days. During those 109 days, she underwent 2 cranioplasties to remove parts of her skull to allow her brain swelling to decrease, as well as a number of other intensive medical interventions and treatments.

Following the September 4th hospitalization, H.H. was removed from Dudney and Hall's care and DCF closed its investigation that was initiated by the September 4th reports with verified findings of:

- Burns;
- Failure to protect;
- Inadequate supervision;
- Medical neglect;
- Threatened harm; and
- Physical injury.

The CPI assigned to investigate after the September 4th hospitalization was CPI Janet Derr. From a review of CPI Derr's notes and reports, she conducted her investigation efficiently, thoroughly, and with great care and attention. Her investigation provided the Special Master with an example of how a reasonable investigation should be conducted; it was a stark contrast to the prior two investigations by DCF.

Following the horrific abuse and torture of H.H., Harold Hall was adjudicated guilty as a principal to:

- Aggravated child abuse;
- Child neglect causing great bodily harm; and
- Possession of a firearm by a convicted felon.

Hall was sentenced to 15 years in prison for each count, to be served concurrently. He has a current projected release date of September 13, 2040.

Amber Dudney was adjudicated guilty as a principal to aggravated child abuse, child neglect causing great bodily harm, and two counts of aggravated child abuse. She was sentenced to 30 years, 10 years and 30 years in prison, respectively. Dudney has a current projected release date of October 8, 2054.

Evidence of Abuse and Torture

Subsequent to the arrests of Dudney and Hall, law enforcement confiscated their cell phones as

evidence of their criminal actions. Subsequent to a review of the data on both cell phones, a trove of disturbing facts, pictures, and videos was discovered. Further, clear evidence of chronic drug use, sales, and purchases was found through hundreds of text messages.

From the evidence gathered after H.H. was hospitalized, it is clear that Dudney and Hall were consistently physically and emotionally abusing H.H. What is more disturbing, is that the evidence illustrates actual abuse that was taking place during the course of the DCF investigations. Among the extremely graphic and disturbing evidence discovered were:

- A photograph Dudney took of H.H. in her car seat with her mouth taped shut and her hands and wrists bound together with multiple layers of tape (photograph was taken on June 29, 2017).
- A plethora of text messages between Dudney and Hall regarding drugs, buying drugs, needing more drugs, using drugs, meeting with a drug dealer, quality of drugs that were being obtained, and glass pipes for smoking drugs.
    - In fact, from a review of the text messages, it is apparent that Dudney and Hall would frequently use drugs in the room or house while the children were present.
- A photograph of H.H., naked and curled up on a storage box with bruises all over her back (photograph taken on July 17, 2017).
- Photographs of H.H. with a severely swollen eye and face (photographs taken on August 29, 2017).
- Photographs of H.H. lying unclothed on a Boppy pillow with black eyes, masking tape covering her mouth, tape bound around her wrists and hands, and bruises and tape residue all over her arms and torso (photographs taken on July 31, 2017).
- Multiple Videos Dudney took of H.H. lying naked on the floor, with her hands bound and taped, crying and screaming for help (videos recorded on August 1, 2017).
- Video taken by Dudney in which Dudney is verbally berating H.H. as she is sitting on the floor crying; calling H.H. names, and scolding her (video recorded on August 7, 2017).
- Video taken by Dudney of H.H. naked in the shower crying as Dudney is telling her, “you are going to stand there and take it.” H.H. is crying and begging her mom to stop (video recorded on August 10, 2017).
- Additional video of H.H. in the shower in which Dudney is forcing H.H. to stand with her head straight into the stream of water and physically grabbing H.H.’s face to force her to do so (video recorded on August 10, 2017).
- Multiple videos (sound only) of H.H. crying, screaming, and hyperventilating while Dudney keeps asking “what do you want?” (videos recorded on August 29, 2017).

Equally as horrific as the photographs and videos were the text messages discovered by law enforcement from Dudney’s and Hall’s cell phones discussing heinous and unthinkable treatment of H.H. The text messages frequently featured discussions of leaving H.H. alone and unattended (she was less than 2 years old) and physically restraining her and silencing her for their own convenience. Additionally, there was evidence of messages related to concealing the abuse of H.H. and conspiring to come up with explanations for her injuries should anyone happen to notice. The two exchanged messages including:

- “How do you tape her face so she can’t scream?...Sorry I just didn’t know if there was something else [yo]u did that I didn’t catch.”
- “This dumbass kid just pissed where she was sitting.”
- “I’m about to put her to sleep and head out…”
- (Hall text to Dudney) “Whatever. Watch that screaming all we need is someone to see her black eye…” (to which Dudney responded) “I’m gonna cover it with makeup of course…IDK maybe I’ll just leave her…H.H.’s face is swollen…”
- “When I get off the phone with [yo]u and just beat the shit out of H.H. she is so tired.”
- “Ok I’ll get stuff together we leaving H.H.”
- “Call me when you can please so I can know what to do with H.H…btw why did [yo]u use this tape on her?”
- “Leaving now…H.H. has been amazing this a.m. [I]t killed me to tape her up so I put her

in living room with cartoons and Benadryl I know don't yell at me please."
- "…[W]hen do [yo]u think [yo]u will be home cause H.H. IDK if I should take her or she fine?"
- "[S]hould I go to the house and check on H.H.?"
- (While out of the house running errands) "…[H]opefully H.H. is good."
- "Do you think you will be able to make it by the house at all to check on H.H. or should I just head that way?"
- "Heading to house [to] check on H.H."
- "…[C]all me when you get a second I guess I'm heading to the house to check on H.H."
- "[H]ow long [yo]u think [yo]u will be working[?] I don't think I feel comfortable taping and going to db."
- "H.H. is back in the tub…I am leaving she is sleeping I didn't tape her."
- "What's the story we're going with about H.H.'s tooth?..." "She fell off the bed…" "got it luv [sic]."

From the DCF investigative report after H.H. was hospitalized, CPI Derr noted that "the mother had evidently taken videos of the child being abused. It is suspected that since starting her relationship with Harold [Hall] she has become involved in the use of Methamphetamine and it is suspected that this may be a contributing factor to the abuse of the child."

Further, photographs taken by law enforcement on September 4 when they responded to the motel room the family was staying in provided significant insight into the conditions the family had been living in. The family appeared to have been living in a small efficiency-style motel room. Details observed from the motel room included:

- Black trash bags that had been taped up to all of the windows to prevent anyone from seeing inside of the room.
- No sheets on the one bed in the room.
- Multiple 5-gallon buckets (similar to what one would purchase at a home improvement store) throughout the room and in the bathtub.
- What appeared to be blood stains on the mattress cover and pillow cases.
- A long hard case with an assault-style rifle and ammunition.
- An empty gun case that appeared set up to contain a handgun.
- A magazine for a handgun and more ammunition.
- An "ammo box" filled with various types of bullets and ammunition, including a gallon-size Ziploc bag filled with loaded bullets and multiple other smaller bags and boxes filled with the same.
- Bullets that were not securely kept anywhere and were mixed in with tools in a toolbox drawer.
- A drawer full of razor blades, superglue, zip ties, and rubber bands.
- A storage box full of gun cleaning supplies, eye protection, and other related items.
- A Uniden radio scanner.
- Black balaclava-type masks.
- A stolen iPad (identifiable as stolen as it had a sticker on the back with the owner's name, picture, and contact information).
- A cooler or other box/container filled with random loose pills, smoking devices, and rolling papers.
- Loose drug residue in drawers.
- Scales (commonly used to measure and weigh drugs).

Of particular note, the photographs taken by law enforcement after H.H. was hospitalized did not include any evidence of a crib, a playpen, any toys or children's belongings or supplies, diapers, toileting supplies, or medical equipment that would reasonably be present in a location where a parent is taking proper care of a toddler and a medically-needy child.

POSITIONS OF CLAIMANT AND RESPONDENT

Claimant's Position

Claimant argues that DCF was negligent and failed to protect H.H. by failing to properly investigate allegations of substance abuse, abuse, and neglect concerning H.H. and leaving her unprotected and in the dangerous care and custody of her mother and step-father. Claimant argues that DCF, as the state agency statutorily charged with conducting child protective investigations, had a duty to ensure H.H.'s safety and prevent further harm to her, but failed to do so. Claimant asserts she is entitled to the remaining amount of her Final Judgment awarded to her by the Volusia County jury ($14,926,640).

Respondent's Position

Respondent (DCF) argues that it was not negligent in its investigations relating to H.H. DCF argues that Claimant's theory of the case is that anyone who uses marijuana while not in the presence of their child should have their child removed from their care. Further, DCF stated to the Special Master that "if the Legislature passes this claim bill, the Department will have no choice but to act in accordance with the direction from the Legislature and bring all such [marijuana-related] cases before the court for emergency shelter." Additionally, DCF argues that, should the Legislature pass this claim bill, it should do so "purely as an act of grace, and without any attribution of the loss suffered by the Family to the Department…" as "the Department did not directly, proximately, or otherwise, cause the harm in this case," and that to suggest otherwise would "serve to create an ex post facto case by case modification of the Department's authority and obligations under ch. 39, F.S."

With respect to the ability to pay the claim bill, DCF argues that any amount appropriated under the claim bill would need to be funded from General Revenue and that if the funds are not paid from General Revenue, "the claim bill would require a Legislative determination that it be paid from Department Trust funds. However, the Department cannot be certain that revenues in these funds would be sufficient. Legislative directives could exceed the balance available within these funds without an allocation of General Revenue dollars from the Legislature to the Department for said payments."

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.[6] 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.[7]

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.

[6] 38 Fla. Jur 2d Negligence s. 1.
[7] Fla. Standard Jury Instruction 401.4 at 57.

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.[8]

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.[9]

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.[10]

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.[11] 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.[12]

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 investigate the allegations. The hotline must be available twenty-four hours a day, seven days a week.[13] Thus, DCF has a statutory duty to protect children under its care and children about 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

[8] Fla. Standard Jury Instruction 401.9 at 63, *Violation of Statute, Ordinance or Regulation as Evidence of Negligence*.
[9] *Iglesia Cristiana La Casa Del Senor, Inc. v. L.M.*, 783 So. 2d 353 (Fla. 3d DCA 2001).
[10] *Spencer v. Assurance Co. of Am.*, 39 F.3d 1146 (11th Cir. 1994) (applying Florida law).
[11] 57 Fl. Jur. 2d. *Welfare* §7 (August 2024) *citing to* s. 20.19(1)(b), F.S.
[12] S. 409. 986(2)(a), F.S.
[13] S. 39.101(1), F.S.

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.[14]

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.[15] 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.[16] [17]

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.[18] As such, the 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 blanket immunity for negligent actions.

Of particular significance in relation to this case, DCF had several specific duties it was required to follow during the investigations into allegations of abuse and neglect. From a review of the applicable Florida statutes, Florida Administrative Code, and DCF Operating Procedures and Policies, DCF clearly had a duty to:
- Speak with the reporter;

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[14] S. 39.101(1)(b), F.S.
[15] S. 39.203(1), F.S.
[16] *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.
[17] *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.
[18] *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 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).

- Review caregiver criminal history;
- Observe the children;
- Interview all caregivers;
- Speak with collateral contacts;
- Gather and review all available information;
- Assess caregiver protective capacities;
- Assess risk; and
- Document contacts timely and thoroughly.

Breach & Causation

Having identified DCF's responsibilities associated with its duty to reasonably investigate, supervise, and protect the welfare of children in the state, there are a few significant breaches as it relates to this specific case.

Breach of the 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 through the investigative process. The DCF CPIs responsible for these investigations did not act reasonably under the circumstances. The most significant failure by DCF was the amount of time that elapsed between receiving the second abuse hotline report and making initial contact with the children and caregivers.

Pursuant to Florida Administrative Code Rule 65C-29.013(1), the CPI must make diligent efforts to locate a family prior to closing the investigation. When the family cannot be located at the time of the initial visit, the CPI must "conduct follow-up visits to the home during different times of the day and night, including weekends." Further, if the family has not been located within 72 hours, the CPI shall re-contact the reporter to attempt to find out the family's location. When the CPI has reason to believe that the family has fled to avoid the investigation, the CPI, CPI supervisor, and counsel from Children's Legal Services must conduct a legal staffing to determine if sufficient probable cause exists to file a shelter petition.

With regard to the second DCF investigation, CPI Boice attempted twice to conduct her initial home visit on June 3 and June 4, both around 8:30 a.m.; no contact with the caregivers was made and no observation of the children took place. On June 6, around 7:30 p.m., CPI Gonzalez made a third attempt at an initial home-visit to no avail. Between June 6 and June 28, no actions were taken to attempt to locate the family. Therefore, there was a 22-day period of time where CPIs did absolutely nothing on the case; thus, due diligence was not used to attempt to locate the family. Further, a reasonable person would have done more to attempt to locate a family who was the subject of not one, but two abuse investigations. The CPIs had no knowledge from the time the second abuse report was made until June 28, 2017, as to whether H.H. and C.H. were even alive.

To add to the gross failure to locate the family, DCF had actual knowledge of Harold Hall's extensive and violent criminal history. Had DCF been acting reasonably, it would have considered the allegations in combination with Hall's criminal history and the inability to locate the family, and escalated the efforts to locate them. It appears that CPI Boice gave little to no weight or consideration to Hall's extensive criminal history, despite the fact that he was a relatively new person introduced into the lives of H.H. and C.H. At the very least, it would be reasonable to conduct collateral interviews with people who knew Hall, such as his actual assigned probation officer, his family, friends, and his employer.

Additionally, DCF was well aware that H.H. and C.H. were particularly vulnerable due to their young ages and not being able to independently care for themselves, C.H.'s extensive medical needs, and the lack of visibility of the children in the community.

Once initial contact with the mother in the second investigation was finally made on June 28, the CPI informed her that she would be coming to the motel to conduct a home visit and notified her that she had ample time before the CPI showed up. The purpose of an unannounced home visit is to provide the CPI with the opportunity to see the actual conditions of the home and children, not a curated and prepared snapshot. By conducting only one home visit, and that home visit being announced with time for Dudney to prepare, the CPI was not able to get an accurate or complete picture of the home; negating the entire reason for a home visit.

After Dudney and Hall were arrested, law enforcement documented a vast collection of firearms, ammunition, and drug paraphernalia present in the motel room. It is completely reasonable to believe, having been told of the time that the CPI would arrive to the house, Dudney had plenty of time to conceal concerning items and make the home appear up to DCF's muster.

Additionally, CPI Bucci, during her visit to the motel on June 28, failed to look through the motel in detail. She failed to open cabinets and drawers and just took a glance around what she could see, after Dudney had been given hours to prepare the motel room for a visit from DCF. A reasonable investigator would have opened cabinets and drawers to look for visible drug paraphernalia, drugs, guns, weapons, adequate food and medication for the children, and clean clothes for the children, and to assess whether dangerous items (such as chemicals, prescriptions, knives, cords, electronics, weapons, etc.) were safely and securely stored out of reach of the children.

Breach of the Duty to Interview All Caregivers and Provide Certain Required Information

Pursuant to ch. 14 of DCF's Operating Procedures ("CFOPs") (2017), the purpose of initial contacts and interviews is to collect information and analysis, including information validation and reconciliation. Further, "establishing a working relationship with the family to facilitate information gathering requires the investigator spend sufficient time establishing and building rapport with the child's parents and caregivers."

Section 39.301(5)(a)6., F.S. (2017), requires a CPI to inform the caregivers of the duty of the parent or legal custodian to report any change in the residence or location of the child to the investigator and that the duty to report continues until the investigation is closed. While it is unknown whether CPI Boice informed Dudney and Hall of this duty during the first investigation, it is clear that they did not keep her informed of their address throughout the pendency of the investigations. CPI Boice testified that Dudney had mentioned something about moving during her visit in the first investigation, but stated that there were no moving boxes, nothing was packed, and it did not look like a move was imminent. Thus, DCF did not act reasonably iwith respect to its disregard of the inability to locate the family, despite having knowledge that they were, allegedly, contemplating a move.

Another significant point of concern, given that the abuse hotline allegations were based upon inadequate supervision and leaving the children home alone at various times, was that DCF did not do more to try to find out if anyone was in the house during the times the CPIs attempted to conduct the initial visit during the second investigation. The Special Master acknowledges that DCF does not have the same authority as law enforcement to enter a residence, however, it would have been reasonable to request assistance from law enforcement to determine if the children were in the home unattended, as the hotline allegations had alleged.

Additionally, Harold Hall was not present during the one home visit, despite it being announced in advance to Dudney, and DCF did not conduct a face-to-face interview with him as is required by law.

Breach of the Duty to Gather and Review all Available Information

From a review of DCF's CFOPs, it is clear that a CPI is expected to work closely with the family

and caregivers in order to thoroughly investigate the allegations. During the first investigation, the CPI only made one visit to the home, despite her supervising CPI providing her a list of specific actions that she needed to complete during the investigation. In fact, in her deposition testimony, Shelby Best, CPI Boice's senior supervising CPI, was upset upon learning that the first investigation had been closed while she was out of the office on vacation. CPI Best specifically recalled discussing the case with CPI Boice prior to leaving for vacation. CPI Best instructed Boice on specific things that needed to still be done on the case and, understandably, CPI Best was upset when she returned from vacation to find out, not only that Boice failed to do the tasks she assigned her to on the case, but that another supervisor had closed the investigation out altogether. Per CPI Best, she would not have closed the case out without having the documentation she requested Boice obtain (which Boice failed to do) in the file.

Specifically, CPI Best testified that she instructed CPI Boice to:

- Ensure complete documentation of her investigative actions in the DCF FSFN system.[19]
- Conduct additional collateral interviews with people that may have relations with the family or have knowledge about the inner workings and dynamics of the family.
    - CPI Best specifically wanted Boice to obtain collaterals as it related to medical concerns of C.H., the allegations involving drug use, and the family dynamics in the household, particularly involving Harold Hall, given his criminal history.[20]
- Obtain local "call-outs" from law enforcement showing the responses by law enforcement to the home.
- Explore in more depth the allegations related to substance misuse.[21]

CPI Best testified that investigators are generally required to close cases within 60 days. However, she also testified that an investigation could remain open for longer than 60 days if needed. She explained that CPI Boice would have needed to "staff it" with the supervisor, probably the program administrator, and maybe the operations manager, just to justify the reason for keeping it open. Thus, while not dispositive of a breach of duty, the decision to close the first investigation in the late hours on day 59 while the assigned supervisor is on vacation seems likely unreasonable.

In fact, CPI Best testified that she had spoken to her program administrator and another staff member about her overall concern that "seniors were closing cases…out from underneath supervisors without reaching out." Further, CPI Best expressed concern that CPI Boice had "kind of gone [through] the back door, for lack of a better word, to get the case closed."[22] In explaining what she meant by that statement, CPI Best testified that rather than having another supervisor get involved or calling Best while on vacation because she knew the case, she had the senior[23] close it after work hours to make the 60-day deadline. The case was closed on July 2, 2017, at 10:23 p.m.

Breach of the Duty to Observe the Children

Similar to the previous failures discussed, DCF failed to observe the children. The sole observations of the children were one time during the initial visit in the first investigation, and one time at the motel in the extremely delayed and expected initial visit in the second

[19] CPI Best recalled that, on a number of occasions, she repeatedly instructed CPI Boice to make sure she was documenting her efforts in the system and that it was a consistent issue.
[20] CPI Best testified that if a child who is subject to an abuse allegation has a medical condition, she would expect there to be medical providers involved that DCF could and should speak to.
[21] CPI Best testified that given the vulnerability of the children due to age and medical needs, she wanted CPI Boice to further investigate the substance misuse allegation to ensure the children were being protected.
[22] It should be noted that CPI Boice was the "senior CPI" in her unit. As such, Boice was unable to close out her own case and needed a supervisor or other senior CPI to sign off on closing the case.
[23] CPI Best testified that the senior CPI that closed the first investigation was not a member of her unit, which was concerning as she would not have had knowledge of the details of the case.

investigation. It is reasonable to assume that, when dealing with young children of a vulnerable age and medical condition, DCF should have visually observed them multiple times to ensure they were uninjured, healthy, and not subject to any unsafe environmental conditions.

In addition to CPI Bucci's brief visit to inspect the motel on June 28, CPI Bucci failed to observe H.H. in any semblance of detail, but rather just noted that she looked fine while fully clothed. CPI Bucci did not take any photographs of H.H.; thus, it is unknown whether she was wearing long sleeves, long pants, or other clothing that would hide visible bruises and injuries. Based upon testimony reviewed, it is common practice for a CPI to observe a child that is the subject of an abuse report during a diaper change or bath or otherwise while unhidden by clothing that could conceal obvious injuries. CPI Bucci did none of that. Given the information and evidence that was gathered after the arrest of Hall and Dudney, it is clear that H.H. did in fact have bruising on her body at the time Bucci conducted her visit to the motel. It was not reasonable of CPI Bucci to simply glance around the motel room and neglect to examine H.H. for injuries.

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.[24]

Concurring Cause

In order to be regarded as a legal cause of loss, injury, or damage, negligence need not be the only cause.[25] 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.[26]

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.[27]

Due to the number of failures by DCF CPIs during the investigations, DCF failed to identify the present and/or impending danger that Dudney and Hall posed to H.H; DCF did not even observe the children for an entire three weeks from the time the second investigation was opened. Had DCF acted reasonably and made more efforts to locate the family, it would have likely discovered the physical abuse that H.H. had been enduring. It would have been nearly impossible to conceal the bruises and injuries to H.H. seen in the photos Dudney had recorded proof of on her phone, even if she had used makeup, as she told Hall she would do in one of her text messages.

It is not enough for a finding of negligence that DCF breached its duties to H.H. Rather, the evidence must show that DCF's breach was a cause of the damages caused to H.H. The

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[24] Restatement (Second) of Torts s. 431 (1965).
[25] *Goldschmidt v. Holman*, 571 So. 2d 422 (Fla. 1990).
[26] *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).
[27] 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).

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 Dudney and Hall 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 Dudney and Hall, and neither DCF nor its CPIs were the ones to torture and abuse H.H.

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 and step-father were the bad actors. Rather, the situation must be assessed to determine whether DCF's actions or inactions were a contributing legal cause of H.H.'s horrific injuries. In the instant case, DCF clearly fell short of its basic duties and responsibilities. DCF failed to conduct an in-person face-to-face visit with the caregivers and the children for more than three weeks after receiving the second investigation. Further, DCF failed to attribute the proper weight to Harold Hall's criminal history when considering the totality of the case. Additionally, with respect to the first investigation, DCF prematurely closed the investigation over the supervising CPI's objections presumably for the sake of convenience and to try to comply with an operating procedure to close cases within 60 days. I find that the complete lack of investigation that went into both the first and second investigations were not reasonable and were a legal cause to the injuries sustained by H.H.

Had DCF conducted a reasonable investigation, it is likely that it would have discovered significant threats to the safety of H.H., which would have warranted safety mechanisms to be put in place. However, DCF failed in its duty to properly and adequately investigate the totality of the circumstances in an effective and efficient manner, and thus, left H.H. in her mother and step-father's care to be abused beyond recognition, completely altering her life.

Damages

The abuse and neglect H.H. suffered by her mother and step-father during the investigations by DCF resulted in catastrophic and permanent injuries, including:

- Traumatic brain damage;
- Cerebral palsy;
- Encephalomalacia[28];
- Ventriculomegaly[29];
- Inability to walk;

[28] Encephalomalacia refers to the softening of or death (necrosis) to brain tissue; it can cause a number of symptoms including a loss of physical function, memory loss, and mood swings. *See* National Library of Medicine, *Encephalomalacia*, https://www.ncbi.nlm.nih.gov/mesh?Cmd=DetailsSearch&Term=%22Encephalomalacia%22%5BMeSH+Terms%5D (last visited March 18, 2025).

[29] Ventriculomegaly refers to a condition in which the brain ventricles, or fluid-filled cavities, are enlarged to build-up of cerebrospinal fluid. Ventriculomegaly results in symptoms including a full or bulging soft spot at the top of the head, bulging veins in the scalp, irritability or sleepiness, developmental delays, abnormal eye movement, poor feeding or projectile vomiting. *See* Nationwide Children's Hospital, *Ventriculomegaly*, https://www.nationwidechildrens.org/conditions/ventriculomegaly (last visited March 18, 2025).

- Inability to talk;
- Inability to sit up or hold her head up independently;
- Dysphagia[30];
- Inability to eat requiring the use of a feeding tube;
- Post-traumatic epilepsy/seizures (which necessitated the implantation of a vagus nerve stimulation device in her chest and surgery;
- Spasticity[31];
- Neuro storming/automatic dysfunction[32];
- Obstructive sleep apnea[33];
- Chronic constipation and gastroesophageal reflux disease;
- Urinary issues; and
- Chronic lung disease/restrictive lung disease.

In November of 2022, H.H. underwent corpus callosotomy surgery[34] to sever the hemispheres in her brain due to her frequent seizures; she underwent a second surgery in January of 2025 to again try to control her seizures.

H.H. receives treatment in multiple medical professional areas including pediatrics, palliative care, neurology, neurosurgery, gastroenterology, pulmonology, orthopedics, and urology. She will continue to require physical therapy, occupational therapy, speech therapy, constant care, monitoring and supervision, multiple medical specialist services, and supportive care 24/7 throughout the rest of her life.

H.H. went from being a normal and healthy toddler to a medically-dependent child as a result of the actions of her mother and step-father and the lack of due diligence by DCF. H.H. is now dependent for all mobility and activities of daily living; she cannot walk, she cannot talk, she cannot eat actual food, she cannot dance, she cannot sit up unassisted, and she will never know a life without seizures, discomfort, and medical intervention. She requires a number of daily medications in addition to a feeding tube.

After the hospitalization for her injuries on September 4, 2017, H.H. has undergone at least 9 additional surgeries and is on 11 different medications, some requiring dosing multiple times a

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[30] Dysphagia is a medical term for difficulty swallowing. In some cases, swallowing becomes impossible. *See* Mayo Clinic, *Dysphagia*, https://www.mayoclinic.org/diseases-conditions/dysphagia/symptoms-causes/syc-20372028 (last visited March 18, 2025).

[31] Spasticity refers to abnormal muscle tightness due to prolonged muscle contraction and is a symptom associated with damage to the brain, spinal cord, or motor nerves. *See* Johns Hopkins Medicine, *Spasticity*, https://www.hopkinsmedicine.org/health/conditions-and-diseases/spasticity#:~:text=Spasticity%20is%20abnormal%20muscle%20tightness,Stroke (last visited March 18, 2025).

[32] Neuro-storming, also referred to as paroxysmal sympathetic hyperactivity (PSH) is a condition characterized by episodes of excessive sympathetic nervous system activity. PSH can manifest in tachycardia (rapid heart rate), hypertension (high blood pressure), tachypnea (rapid breathing), hyperthermia (fever), diaphoresis (sweating), increased muscle tone (rigidity or spasms), and dystonic posturing (abnormal or fixed postures). Some triggers for PSH include painful stimuli (passive movement, turning, or suctioning), environmental stimuli (bright lights or loud noises), medication changes or withdrawal, and various self-care activities (bathing or feeding). *See* National Library of Medicine, *Paroxysmal Sympathetic Hyperactivity: The Storm After Acute Brain Injury*, https://pubmed.ncbi.nlm.nih.gov/28816118/ (last visited March 18, 2025).

[33] Obstructive sleep apnea is a sleep disorder characterized by recurrent episodes of complete or partial blockage of the upper airway during sleep, resulting in reduced or absent breathing. Mayo Clinic, *Obstructive Sleep Apnea*, https://www.mayoclinic.org/diseases-conditions/obstructive-sleep-apnea/symptoms-causes/syc-20352090#:~:text=Obstructive%20sleep%20apnea%20occurs%20when,breathing%20is%20momentarily%20cut%20off. (last visited March 18, 2025).

[34] *See* Cleveland Clinic, *Corpus Callosotomy*, https://my.clevelandclinic.org/health/treatments/11546-corpus-callosotomy (last visited March 18, 2025).

day. Currently, H.H. requires a wide variety of services including:

- Nursing Care[35] including:
  - Positioning (bed, bathing, and diaper changes).
  - Daily passive range of motion to arms and legs.
  - Baths.
  - Total lift transfers and carries.
  - Tube feedings.
  - Medications.
  - Diapers and catheterizations.
  - Cough assist and chest vibrator as well as suction for lung support.
  - Various creams and lotions.
  - At least one person always remaining nearby.
- Physical Therapy (3 times a week);
- Occupational Therapy (3 times a week); and
- Speech Language Pathology (3 times a week).

H.H. has a life expectancy of 36.81 years due to the injuries sustained in 2017. Based upon an economic analysis completed by Frederick Raffa PhD., with Raffa Consulting in conjunction with the life care plan created by Dr. Ronald Snyder, the present value of total economic loss to H.H. for her current life expectancy ranges from $14,334,393 to $22,040,894, dependent on the type of care (home care vs. facility care) and pre-employment education level (high school diploma vs. Associate's Degree).

AMOUNT OF CLAIM BILL

The claim bill is based upon a $14,926,640 jury verdict plus a Final Cost Judgment of $126,639.56 issued by a Volusia County jury for the benefit of H.H. To date, Claimant has received the sovereign immunity limit of $200,000 from DCF. Thus, Claimant is seeking the remaining $14,926,640 owed under the Final Judgment. Claimant has not received any other funds from any collateral sources. If the bill passes, the funds received will be placed into a trust for the benefit of H.H.

Pursuant to the bill, it is the intent of the Legislature that all government liens, including Medicaid liens, resulting from the treatment and care of H.H. for the treatment of the injuries sustained from the occurrences described in the bill, be waived and paid by the state. Pursuant to the Claimant's affidavit, the outstanding Medicaid liens total $394,586.50.

LITIGATION AND LEGISLATIVE HISTORY

This claim is based upon a Volusia County trial and subsequent jury verdict rendered in December of 2023. The jury found in H.H.'s favor and determined DCF was negligent in its in investigation of H.H., and that such negligence was a legal cause of the injuries sustained by H.H. The jury awarded H.H. total damages amounting to $14,926,640 and assigned the following values to damages at trial:

- $500,000 for loss of earning capacity in the future;
- $250,000 in past medical expenses[36];
- $10 million in future care and medical expenses;
- $250,000 for pain and suffering, disability, physical impairment, disfigurement, mental anguish, deterioration, discomfort, and loss of capacity for the enjoyment of life in the past; and

[35] Currently her maternal grandmother and maternal aunt are responsible for the majority of her nursing care; however, as H.H. gets older and grows bigger, she will likely need additional, professional nursing care.

[36] At trial, both parties stipulated to the amount of $383,029.35 in past medical expenses; DCF agreed that the past medical expenses were reasonable and necessary.

- $4 million for pain and suffering, disability, physical impairment, disfigurement, mental anguish, deterioration, discomfort, and loss of capacity for the enjoyment of life in the future.

Additionally, the court issued a Final Cost Judgment ordering DCF to pay an additional sum of $126,639.56 to H.H. as taxable costs.

This claim is being heard for the first time during the 2025 Legislative session.

ATTORNEY AND LOBBYING FEES

If the bill passes, Claimant attests that attorney fees will not exceed 20% of the total amount awarded ($2.985 million) and lobbying fees will not exceed 5% of the total amount awarded ($746,332). Outstanding costs, as sworn to by the Claimant, are $126,639.56, which have been included in a Final Cost Judgment ordered by the court to be paid if H.H. recovers under this claim bill. Additionally, there are outstanding liens in this matter that will need to be satisfied should the bill pass and Claimant receives payment. The outstanding liens total $394,586.50 and include:

- $132,444.89 owed to United Healthcare Medicaid;
- $15,155.97 owed to Sunshine Health Medicaid;
- $136,860.31 owed to WellCare of Florida-Staywell Medicaid; and
- $120,125.33 owed to Children's Medical Services from Sunshine Health Medicaid.

RECOMMENDATION

Based upon the evidence presented and the totality of the circumstances, I recommend that CS/HB 6531 be reported FAVORABLY.

Respectfully submitted,

SARAH R. MATHEWS

House Special Master