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 LaMarca
Relief/Estate of M.N./Broward County Sheriff's Office

SUMMARY

This is a contested claim for local funds in the amount of $2,498,258.50 by the Estate of M.N. (hereinafter referred to as "Claimant") against the Broward County Sheriff's Office ("BCSO") based on a jury verdict which found BCSO negligent with respect to the death of six-month-old M.N. This claim arises out of negligence in the context of the investigation by BCSO, as the statutorily-contracted provider of child protective investigations for Broward County, in response to abuse reports called into the state's child abuse Hotline ("Hotline").

FINDINGS OF FACT

M.N., a female, was born on April 20, 2016, to parents Christopher Nevarez ("Nevarez") and Keisha Walsh ("Walsh"). From birth through approximately September 14, 2016, M.N. and her brother, D.N. (5 years old), had been living with Walsh in M.N.'s paternal grandmother's (Ann McClain) house, along with Ms. McClain; Nevarez was not living with Walsh and the children as they were not together as a couple and he maintained his own residence with his girlfriend. Ms. McClain allowed Walsh and the children to move in with her so that the children had a safe and permanent home. Ms. McClain testified at the Special Master Hearing that Walsh moved into her house while she was pregnant with M.N.

Nevarez and Walsh shared care and responsibility for M.N., alternating watching the children while the other had to be at work. Usually, Nevarez would care for M.N. at Ms. McClain's house. From the evidence and testimony provided, it appeared the Nevarez would go to Ms. McClain's house very regularly, and that Walsh, Nevarez, and McClain all helped to care for the children as a "community team."

On September 14, 2016, Nevarez and Walsh had a disagreement and Walsh abruptly moved her and the children out of Ms. McClain's house and into Juan Santos' home with his daughter, K.S.[1]

[1] Juan Santos was a friend and co-worker of Walsh.

By his own testimony, Nevarez did not attempt to make direct contact with Walsh for approximately two weeks after the dispute on September 14. However, he testified that he went through his mother, Ms. McClain, to check on the well-being of the children during those two weeks. Further, Nevarez testified that it was not unusual for Walsh to get agitated and act impulsively; this sort of behavior from Walsh had happened before and Nevarez handled the situation by keeping his distance and allowing her time to "cool off." Nevarez believed that Walsh would move back into McClain's home eventually.

McClain testified that she maintained sporadic text message communication with Walsh after she moved out of the home. However, Walsh would not inform McClain as to where she and the children were living.

During the period of time from September 14 through October 13, 2016, Nevarez and Walsh both attempted to contact and visit the children by:

- Texting Walsh at the number previously used to contact her (although it was unclear whether the text messages were actually received by Walsh)[2];
- Asking for Walsh at her work;
- Attempting to visit D.N. at his school[3]; and
- Obtaining assistance from McClain and friends who attempted to follow Walsh's car home from work to learn where she was living.

Medical History of M.N.

June 7, 2016 (West Boca Hospital)

On June 7, 2016, M.N. was treated in the emergency room at West Boca Hospital suffering from severe choking, foaming at the mouth, red face, and bulging eyes. The injuries were suspected to have occurred while M.N. was under Walsh's care.

August 19, 2016 (Broward Health)

On August 19, 2016, Walsh brought M.N. to Broward Health Hospital with reports of injuries she sustained when M.N. (4 months old) fell off of a couch at Juan Santos' home. M.N. had a black eye from the alleged fall. M.N. underwent x-rays, but no fractures were identified at the time.

Nevarez was not present for the injury M.N. sustained on August 19, nor was he present for the subsequent hospital visit. However, Nevarez accompanied Walsh and M.N. to a follow-up medical visit at Personal Care Pediatrics, as instructed by the hospital staff who initially assessed M.N. During the appointment at Personal Care Pediatrics, Nevarez spoke with the doctor about M.N.'s injuries. Specifically, Nevarez asked whether the child's injuries were the likely result of a fall, as Walsh had alleged. The doctor told Nevarez that it was possible her injuries were from a fall.

October 13, 2016 (Northwest Medical Center)

On October 13, 2016, Walsh brought M.N. to Northwest Medical Center (a third hospital different from where she had brought M.N. for prior injuries) with concerns of a fever and leg pain. M.N. was admitted under the care of Dr. Font in the emergency room ("ER") at around 3:23 p.m. Dr. Font asked Walsh about possible causes of the leg pain to M.N., to which Walsh reported that there was no recent trauma or injury and that she could not provide any explanation for the pain.

[2] Nevarez testified that he believed Walsh had blocked his number from her phone and questioned whether she ever actually received his text messages.
[3] Nevarez testified that when he attempted to see his son, D.N., at his school, he discovered that Walsh had removed him from the school contact list and he was unable to see D.N.

Dr. Font ordered x-rays and around 5:00 p.m., and based on the x-rays, diagnosed M.N. with "subacute fractures in her left proximal tibia and fibula (shin and calf)." At that point, due to the fractures observed, M.N.'s vulnerable and young age, and Walsh's inability to provide any kind of explanation for M.N.'s symptoms, Dr. Font called the Hotline and reported M.N.'s injuries as "suspected abuse." At 5:45 p.m., a note was entered into M.N.'s chart documenting the call to the Hotline.

After making the first call to the Hotline, Dr. Font informed Walsh of the fractures observed on the x-rays. Walsh then explained that M.N. had fallen from a couch two months prior and was seen at North Broward Hospital where she underwent a CAT scan and x-rays. Dr. Font obtained and reviewed M.N.'s medical records from the August trip to North Broward Hospital and then proceeded to contact M.N.'s treating pediatrician to discuss her medical history.

Around 5:20 p.m., Dr. Font spoke with an orthopedic specialist, Dr. Mark Fortney, who opined that he did not believe, based on the images, that M.N.'s present fractures were related to a fall from the couch two months earlier. He further explained that he believed her present injuries were likely sustained 3-4 weeks earlier and suggested that the injuries may be non-accidental. Dr. Fortney recommended that Dr. Font report the injuries to the Hotline.

Around 5:45 p.m., Dr. Matthew Buckler conducted a "bone osseus survey" of M.N.'s x-rays. In consultation with Dr. Font, Dr. Buckler explained his findings of a "partially healed left proximal tibial and fibular metaphyseal fracture with perostitis" as well as a "additional distal left radial metaphyseal fracture.

At 7:00 p.m., Dr. Font's shift ended and she was scheduled to go home for the night. However, due to her concerns for M.N., and her belief that a child protective investigator ("CPI") would be arriving soon to investigate, she remained at the hospital for over an hour after her shift. Dr. Font left the hospital around 8:00 p.m.; at that point, no investigator had shown up to the hospital and no CPI had contacted her about M.N. Dr. Font later testified that, at no point did anyone from BCSO or DCF reach out to her, as the mandatory reporter or as the treating physician, to discuss the abuse report concerning M.N.

Around 9:25 p.m., M.N.'s treating nurse noted in her medical file that an additional call was made to DCF to inquire as to the status of the CPI's arrival time at the hospital for the investigation. Records indicated that at 10:13 p.m., it was discovered that DCF had erred in "keying in" the abuse report allegations. At that point, hospital staff was told that a CPI would arrive at the hospital in about three hours. It should be noted, however, that the response type identified in the DCF Confidential Investigative Summary for the October 13 report was a 24-hour response priority.

October 24, 2016 (Broward Health North)

On October 24, 2016, M.N. was brought to North Broward Medical Center by EMS and was unresponsive. While at Mr. Santos' home, under Santos' care while Walsh was at work, M.N. began spitting up and became unresponsive and was not breathing. When EMS arrived to the home, M.N. had no pulse; EMS began CPR and transported her to the hospital. After arriving at the hospital, M.N. regained a pulse and was subsequently diagnosed with a skull fracture and brain bleed. She was airlifted to Broward General Medical Center for care in their pediatric unit.

M.N. was placed on a ventilator. Subsequently, M.N. was removed from life support and, tragically, M.N. passed away from her injuries on October 28, 2016; she was six-months old. A review of medical and autopsy records provided that M.N. had suffered multiple traumas which were consistent with non-accidental injury. The medical examiner identified the cause of death to M.N. as "blunt force head injury," and identified the manner of death a "homicide." The medical examiner identified the following injuries sustained by M.N. prior to her death:

- Blunt force head injuries, including:
    - Subgaleal hemorrhage in the frontal right parietal and occipital regions;

    - Skull fractures;
    - Bulging anterior fontanel;
    - Subdural membrane with hemorrhage and intra-dural hemorrhage;
    - Cerebral edema;
    - Cerebral congestion;
    - Subarachnoid hemorrhage; and
    - Blood clot in lateral ventricle, cortex with microscopic parenchymal hemorrhage.
- Additional injuries, including:
    - Spinal cord subarachnoid hemorrhage and microscopic parenchymal hemorrhage;
    - Spinal cord gray matter necrosis;
    - Hemorrhage in the left optic nerve;
    - Bilateral retinal hemorrhages;
    - Fractures of both femora;
    - Fractures of the left tibia and fibula; and
    - Fractures of the left radius and ulna.

The medical examiner indicated in his report that the source of the injuries was non-accidental trauma.

DCF Abuse Hotline Report and Investigative Timeline

On October 13, 2016 (5 months old), in response to a call from Dr. Font, a statutory mandatory reporter, BCSO received its first abuse report regarding M.N. from DCF's Abuse Hotline. The report alleged that M.N. had multiple unexplained fractures in different stages of healing and had previously sustained a black eye two months prior. Thus, BCSO had knowledge, based on information included in the abuse report, that M.N. had three unexplained fractures (left shin, left calf, and left forearm), which were all in different stages of healing. BCSO physically observed M.N. to also have a bruise to her left eye and a discoloration on her left wrist. Based on the evidence provided at the hearing on the claim bill, BCSO had knowledge that M.N. had a history of unexplained injuries in addition to the present injuries observed on October 13, 2016. BCSO had knowledge that:

- M.N. had an apparent life-threatening event in June of 2016 when she stopped breathing while in Walsh's care (2 months old); and
- M.N. sustained a black eye in August of 2016 while in Walsh's care at Mr. Juan Santos' home (4 months old).

CPI Henry was dispatched around 10:15 pm to investigate the alleged abuse. CPI Henry arrived to the hospital and conducted her initial face-to-face interview with M.N. and Walsh at around 10:54 p.m.

When asked about the previous injuries to M.N., Walsh could not provide an explanation as to how the child sustained such significant injuries. Walsh's only explanation was that the injuries must have happened while M.N. was with the "Portuguese babysitter." Further, Walsh did not and could not provide a name or address for the alleged "Portuguese babysitter"; BCSO was never able to make contact with anyone purported to be the "Portuguese babysitter" throughout the pendency of the investigations.

CPI Henry spent no more than 10 minutes with M.N. and Walsh. CPI Henry's chronological notes documenting her investigation (entered the following afternoon) detailed a contact with the Hotline reporter. However, Dr. Font testified that she never spoke with a CPI in regards to M.N. CPI Henry met with Nurse Margaret Vincent at 11:05 p.m. but did not speak to any other medical providers while she was at the hospital.

At approximately 11:38 p.m., BCSO permitted the hospital to discharge M.N. into Walsh's care, despite the pattern of unexplained, significant injuries, including broken bones while the child was under Walsh's care. BCSO instituted a "Safety Plan" to ensure the protection and safety of

M.N. However, the Safety Plan was solely based upon promises made by Walsh, with no oversight of such promises by any other responsible adult or entity. The Safety Plan included promises by Walsh to:

- Not leave M.N. with the "Portuguese babysitter";
- Enroll M.N. in a licensed daycare; and
- Notify BCSO as to who was going to be caring for M.N. while Walsh was at work.

Upon leaving the hospital, CPI Henry visited Mr. Santos' home, where Walsh and the children were also living; she was accompanied to the home by BCSO Law Enforcement. CPI Henry completed a Child Present Danger Assessment on October 13 specifying "no finding of a present danger threat to M.N." Her Assessment hypothesized that M.N.'s fever could have been the result of teething and that the leg symptoms were from a reported fall from the couch in August. Of significant note, in CPI Henry's Present Danger Assessment, she indicated that there was no "serious illness or injury (indicative of child abuse) that is unexplained, or the Parent's explanations are inconsistent with the illness or injury."

With respect to CPI Henry's investigation, evidence was presented that she:

- Called the Child Protective Team ("CPT") to refer M.N.'s case on October 14, the day after she went to the hospital to meet M.N. and Walsh;
- Received and uploaded M.N.'s medical files from Northwest Medical Center on October 15 (the record did not reflect that CPI Henry reviewed the medical files); and
- Attempted to call the "Portuguese babysitter" once on October 17, but no contact was ever made.

The evidence illustrated that at no point did CPI Henry contact Nevarez or Ms. McClain. CPI Henry did not even attempt to notify Nevarez that M.N. was the subject of an abuse allegation. Nevarez found out about the October 24 hospitalization from a friend and subsequently went to multiple hospitals to attempt to locate his daughter.

A subsequent DCF investigation was opened following M.N.'s death with respect to the safety of Nevarez's other child, D.N. D.N. was removed from Walsh's care and placed with Nevarez.

POSITIONS OF CLAIMANT AND RESPONDENT

Claimant's Position

Claimant alleges that he is entitled to the remaining $2,498,258.50 of the Final Judgment award entered in favor of the Estate of M.N. Claimant argues that BCSO, acting on behalf of DCF, was negligent in its investigation of the abuse report made to the Hotline, leaving six-month old M.N. in the care and custody of her mother and her mother's roommate, despite several unexplained and severe injuries. During the pendency of the investigation, while under Walsh's care, M.N. was subjected to severe physical abuse and sustained critical and fatal injuries. Claimant argues that such negligence was a legal cause of the injuries to and death of M.N.

Respondent's Position

BCSO initially denied any liability for the injuries to and death of M.N. However, during the jury trial on the matter, and subsequently in its statements to the Special Masters, BCSO admitted its culpability as it related to M.N.'s death.

Respondent argues that Nevarez, as a surviving parent to M.N., should not be awarded any amount of funds. Respondent explains that, during the trial on the matter, the jury attributed 36.6% of fault to Nevarez, and argues that Nevarez was "a substantially absentee father after M.N.'s birth." Respondent argues that claim bills are "not intended as vehicles to enrich tortfeasors and criminals…and Nevarez should not be permitted to manipulate the claims bill process and profit from his daughter's death after his own negligence was a significant cause of that death."

BCSO testified that it has no available insurance covering this claim.

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.[4] 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.[5] It is important to note, that 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.[6]

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.[7]

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.[8]

Duty

Child Protective Investigations and the Department of Children and Families

---

[4] 38 Fla. Jur 2d Negligence s. 1.
[5] Fla. Standard Jury Instruction 401.4 at 57.
[6] Fla. Standard Jury Instruction 401.9 at 63, *Violation of Statute, Ordinance or Regulation as Evidence of Negligence*.
[7] *Iglesia Cristiana La Casa Del Senor, Inc. v. L.M.*, 783 So. 2d 353 (Fla. 3d DCA 2001).
[8] *Spencer v. Assurance Co. of Am.*, 39 F.3d 1146 (11th Cir. 1994) (applying Florida law).

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.[9] 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.[10]

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.[11] 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.[12]

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.[13] 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.[14] [15]

---

[9] 57 Fl. Jur. 2d. *Welfare* §7 (August 2024) *citing to* s. 20.19(1)(b), F.S.
[10] S. 409. 986(2)(a), F.S.
[11] S. 39.101(1), F.S.
[12] S. 39.101(1)(b), F.S.
[13] S. 39.203(1), F.S.
[14] *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.

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.[16] 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 complete immunity for negligent actions.

BCSO as the Contracted Provider of Child Protective Investigations

In 1998, the Legislature passed House Bill 3217, which created a pilot program whereby DCF contracted with the Manatee County Sheriff's Office to conduct child protective investigations on its behalf. In 1999, the program was expanded to include Pinellas, Broward, and Pasco counties as well as Manatee County. As such, DCF was authorized to enter into contracts with those Sheriff's Offices to handle the child protective investigations in their respective counties. At that point, Florida was the first state in the country to turn over complete control of child maltreatment investigations to a law enforcement agency.[17]

The BCSO created its Child Protective Services Section ("CPIS") which functioned as a component of the Department of Law Enforcement. In 2015, the CPIS consisted of three platoons of five squads each. The mission of the CPIS was "to enhance the health and safety of Broward County's children while concurrently supporting their families by providing effective, fair, efficient, and timely child protective investigations involving cases of child neglect, abuse, or abandonment."[18]

Subsequently, in 2023, the Legislature passed HB 7061, which required the sheriff's offices providing child protective investigations to transfer all responsibility for such services back to DCF by December 31, 2023. As such, as of January 1, 2024, Broward County (and all other county sheriff's offices that had been providing child protective investigations) ceased that contracted function; DCF reassumed all responsibility for child protective investigations throughout the state and continues to maintain that duty to date.

With respect to the child protective investigations concerning M.N., the BCSO (specifically the BCSO Child Protective Investigations Section) was the entity responsible for protecting children that were the subjects of abuse report hotline allegations in and for Broward County. Effectively, BCSO, as the statutorily-contracted authority, was acting in the capacity as the agency responsible for child protective investigations that DCF does today. Thus, BCSO had the same duties related to the protection of children that DCF possesses.

---

[15] *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.

[16] *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).

[17] Florida House of Representatives: Health and Human Services Committee, *House Bill 7061: Final Bill Analysis* (May 4, 2023), at 5.

[18] Cpt. Patrick Murray, *BCSO Internal Memo: Child Protective Investigations SOP Revision Section 2.5.1 Entitled "Response Priority Changes*," 1 (Sept. 9, 2015).

When an investigation has either been designated as requiring an "immediate response" by the Hotline, or a supervisor upgrades an investigation from the standard 24-hour response to an "immediate response" matter, the investigator must attempt the initial face-to-face contact with the alleged child victim as soon as possible, but not more than 4 hours after assignment from the Hotline. A designation requiring an "immediate response" time is given when a present danger threat to the child is believed to exist.

A "present danger threat" is defined as "an immediate, significant, and clearly observable family condition that is occurring in the household at the time the reporter contacts the Hotline."[19] With respect to M.N., specifically, BCSO examples of present danger would include, but are not limited to:

- Serious or unexplained physical injury.
- A vulnerable child currently not being supervised.
- A child in need of immediate medical care.[20]

Further, pursuant to BCSO standard operating procedures, the following situations should not be downgraded from an immediate response:

- The immediate safety or wellbeing of a child is endangered;
- The child is with Law Enforcement or a medical professional and they believe the child is in imminent danger if returned to the parents/caregiver;
- A medical neglect allegation wherein child's present health or their mental health condition is presently threatened; and
- The reported victim is hospitalized (fractures, shaken baby, burns, etc.) and siblings age five-years or younger are in the household.[21]

With respect to six-month old M.N., BCSO, at a minimum, had a clear duty to:

- Ensure M.N.'s safety;
- Prevent further harm to M.N.;
- Review all relevant background information on pertinent family and household members, which must include searches of the pertinent individuals in the:
    - DCF Computer System ("FSFN");
    - Department of Health Vital Statistics;
    - Broward County Court Records ("DOCKETRAC");
    - Florida Crime Information Center ("DCIC");
    - National Crime Information Center ("NCIC");
    - Florida Department of Law Enforcement ("FDLE") Sexual Predators/Offenders Database;
    - Department of Juvenile Justice ("DJJ");
    - Department of Corrections ("DOC");
    - Florida Clerk of Courts Comprehensive Case Information System ("CCIS"); and
    - Broward County Jail Management System.[22]
- Timely respond to a report received by the abuse hotline[23];
- Contact the Child Protection Team ("CPT") to discuss all reports involving fractures of a child;
- Make a good faith effort to contact the reporter;
- Interview the parents, legal custodians, care givers, and adult household members;

---

[19] *Id*.
[20] *Id*. at 13, 14.
[21] *Id*.
[22] *Id*. at 11.
[23] Pursuant to BCSO standard operating procedures outlined in the Sept. 9, 2015 *Internal Memo*, in cases designated from the hotline as warranting an "immediate response," the investigator must attempt to make the initial face-to-face contact with the alleged child victim as soon as possible, but no later than 4 hours following the assignment by the Hotline. The "commencement clock" begins at the point the Hotline either assigns the report to the local Receiving Unit or makes contact with an "on-call" investigator. *Sept. 9, 2015 Internal Memo*. at 13.

- Interview medical providers as to the injuries to M.N.; and
- Contact and interview the non-offending parent.[24]

Breach

Once a duty is found to exist, whether a defendant was negligent in fulfilling that duty is a question for the finder of fact.[25] A fact finder must decide whether a defendant exercised the degree of care that an ordinarily prudent person, or child protective investigator in this instance, would have under the same or similar circumstances.[26]

From a review of the totality of the evidence presented at the trial on this matter and at the claim bill hearing before the House and Senate Special Masters, I find that BCSO failed to take the following steps in the initial phase of the investigation, which a reasonable and prudent person would have taken[27]:

- Contact and interview Nevarez, the non-offending parent.[28]
- Contact CPT immediately upon arrival to the hospital to meet the alleged child victim.[29]
- Conduct a face-to-face interview with Mr. Santos, a known adult housemate.
- Request (within 24 hours) a criminal and abuse history of Mr. Santos.[30]
- Implement a proper and reasonable safety plan.[31]
- Contact and speak with the treating physician at the hospital; in this case, that was also the reporter who called the Hotline.
- Obtain necessary collateral contacts and interviews, including relatives, friends of the mother, babysitters, physicians, and other third parties with knowledge of the child and family.
- Review the medical history and available files for the alleged child victim.
- Reasonably and prudently investigate the allegations of abuse.

It would have been prudent, and in fact was required by Departmental policy and regulation, for

---

[24] Pursuant to DCF CFOP 14-2(i), the non-offending parent should be the first adult interviewed after an investigation is commenced.
[25] *Yamuni, 529 So. 2d* at 262.
[26] *Russel v. Jacksonville Gas Corp.*, 117 So. 2d 29, 32 (Fla 1st DCA 1960) (defining negligence as, "the doing of something that a reasonable and prudent person would not ordinarily have done under the same or similar circumstances, or the failure to do that which a reasonable and prudent person would have done under the same or similar circumstances").
[27] It is understandable that all information cannot be obtained instantaneously at the onset of an investigation. However, in the instant case, none of the reasonable steps were taken during the nearly 2-week time period from the date DCF received the abuse allegations and the time M.N. was fatally abused. A reasonable person would have made attempts to thoroughly conduct the investigation and complete these steps within the first few days of the investigation.
[28] One of the first contacts a CPI must make during the initial phase of an investigation is to contact the "non-offending parent." CPI Henry had knowledge that Nevarez was M.N.'s father and did nothing to attempt to contact him. There was dispute regarding the information, or lack thereof, that Walsh provided CPI Henry about Nevarez's involvement in the children's lives, however, CPI Henry had actual knowledge that Nevarez was the other parent and should have been contacted by the CPI. A CPI must attempt to contact the non-offending parent, and if unsuccessful, must make daily attempts thereafter. CPI Henry's records do not include any attempt, let alone daily attempts, to contact Nevarez.
[29] With respect to a case involving a child with unexplained bone fractures, the CPI is required to contact the CPT immediately. In this case, CPI Henry did not reach out to the CPT until the following afternoon.
[30] Upon discovering the presence of an additional adult (not the parents) household member who was not screened by the Florida Abuse Hotline at the time of the initial report, the CPI must, within 24 hours of learning of that adult, request an abuse history and a criminal history of the adult.
[31] The Safety Plan created on October 13, 2016, was in violation of BCSO standards as it was purely promissory in nature. The Safety Plan did not include any other person or entity outside of the home to oversee the Safety Plan and ensure the child's safety. By not creating a proper Safety Plan, BCSO essentially left M.N. in the same position she would have been without the Safety Plan that was agreed to. That is, Walsh made promises to do certain things or refrain from doing certain things, however no oversight or other mechanism was included in the plan to ensure those promises were kept.

the CPI to follow-up on these steps to shed more light on the incident and gather more information about the unexplained injuries to M.N. Instead, CPI Henry appears to have accepted Ms. Walsh's explanation of the significant injuries that the "Portuguese babysitter" and a fall from the couch were the sources of the injury without attempting to verify those allegations through additional investigation.

Even though BCSO has up to 60 days to complete an investigation,[32] BCSO failed to take precursory and required steps that an ordinary prudent CPI would have taken in this instance. For these reasons, I find that the BCSO breached its duty of care.

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.[33]

Concurring Cause

In order to be regarded as a legal cause of loss, injury, or damage, negligence need not be the only cause.[34] 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.[35]

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.[36]

In order to prove negligence, the claimant must show that the breach of duty caused the specific injury or damage to the plaintiff.[37] Proximate cause is generally concerned with "whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred."[38] To prove proximate cause, the Claimant here must submit evidence that "there is a natural, direct, and continuous sequence between [BCSO's] negligence and [M.N.'s] death such that it can be reasonably said that but for [BCSO's] negligence, the abuse to and death of [M.N.] would not have occurred."[39]

The record is replete with evidence to support a finding that BCSO had a duty to investigate the child abuse allegations and owed such duty specifically to M.N. BCSO breached that duty by failing to appropriately identify the present danger to M.N. under the care of her mother and Mr.

---

[32] Section 39.301(17), F.S. (2010).
[33] Restatement (Second) of Torts s. 431 (1965).
[34] *Goldschmidt v. Holman*, 571 So. 2d 422 (Fla. 1990).
[35] *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).
[36] 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).
[37] *Stahl v. Metro Dade Cnty.*, 438 So. 2d 14 (Fla. 3rd DCA 1983).
[38] *Amora*, 944 So. 2d at 431.
[39] *Id.*

Santos. BCSO failed to request a criminal and abuse history of Mr. Santos within 24 hours of learning that he lived in the home with Walsh and the children. Santos' criminal history included charges of:

- Grand theft of a motor vehicle;
- Domestic violence (felony battery-strangulation); and
- Possession of cannabis and drug paraphernalia.

If BCSO had obtained Santos' criminal history, the CPI likely would have been required to remove M.N. from Santos' home, and Santos would not have had the opportunity to fatally abuse M.N.

BCSO's failure to reasonably and prudently investigate the allegations foreseeably and substantially caused the fatal injuries inflicted upon M.N. Claimant presented evidence that there was a natural, direct, and continuous sequence between BCSO's negligence and M.N.'s death such that it can reasonably be said that but for BCSO's negligence, the fatal injuries to M.N. would not have occurred.

Damages

According to testimony by Claimant's expert, Dr. Shawn Gough-Fibkins, a pediatric neuroradiologist, M.N.'s injuries were clearly caused by one thing: "she was shaken or thrashed in some fashion." Further, he testified that the exact type of thrashing or shaking had happened more than once, as illustrated by the healing fractures and the new injuries. Dr. Gough-Fibkins hypothesized that the injuries to M.N. were caused by someone grabbing her by the ankles and then picking her up and thrashing her or violently shaking her.

With respect to M.N.'s skull fractures, Dr. Gough-Fibkins explained that the skull, even in a small child, is not an easy bone to fracture; to fracture a skull in this manner takes "a significant amount of force." Further, he testified that, based upon the appearance of the skull fractures, the injury was fresh and could not be attributed to a fall from a couch two months prior. He explained, as to images of M.N.s head injuries, "it's a horrible picture of a brain death here."

Based upon testimony from Claimant's expert, M.N. and Nevarez would have lived another 51.5 years together had she not been tragically killed. Nevarez now faces a lifetime without his daughter and has to live with the knowledge that he will miss out on approximately 52 birthdays, various grade school activities and events, high school graduation, M.N.'s first date, and college graduation. Nevarez will never get to attend his daughter's wedding and will never know grandchildren from M.N. He was robbed of a lifetime of memories with M.N.

As the beneficiary of M.N.'s estate, the jury in this matter awarded Claimant a Final Judgment of $2.61 million for his mental pain and suffering (reduced to account for his attributed portion of fault). The jury also awarded costs of $88,258.50, reflected in a Final Cost Judgment.

AMOUNT OF CLAIM BILL

This claim bill is based upon a $2.61 million award issued by a Broward County jury to the Estate of M.N. and a cost judgment of $88,258.50. To date, Claimant has received $90,000 from Broward County; based on testimony presented, the BCSO has attempted to tender the $110,000 it owes under the sovereign immunity cap; however, it is the undersigned's understanding that Claimant has not received the funds. As such, if the bill passes, a total of $2,608,258.50 is owed by the BCSO to the Claimant.

LITIGATION AND LEGISLATIVE HISTORY

In the civil matter filed in the interest of M.N.'s estate, a jury found that BSCO's inactions proximately caused M.N.'s death. With respect to the criminal liability for M.N.'s death, Santos was adjudicated guilty to aggravated manslaughter of a child and aggravated child abuse. He

was sentenced to 14 years in prison followed by 20 years of probation.

The Broward County jury awarded Christopher Nevarez damages in the amount of $4.5 million. However, the jury attributed 58% of the fault to BCSO; 2.7% of the fault to Ann McClain, 2.7% of the fault to Personal Care Pediatrics, and 36.6% of the fault to Christopher Nevarez. As such, the initial award for $4.5 million was reduced by Nevarez's assigned portion of responsibility.

This claim bill is being heard for the second time during the 2026 Legislative session. Last session, CS/HB 6533 passed the House but died in the Senate.

ATTORNEY AND LOBBYING FEES

If the bill passes, Claimant attests that attorney fees will not exceed 20 percent of the total amount awarded ($482,000) and lobbying fees will not exceed 5 percent of the total amount awarded ($120,500). Outstanding costs total $174,950.55.[40]

RECOMMENDATION

Based on the evidence presented, I recommend that HB 6531 be reported FAVORABLY.

Respectfully submitted,

SARAH R. MATHEWS

House Special Master

[40] The total outstanding costs includes a $88,258.50 Cost Judgment previously entered by the court and an additional $86,692.05 in costs accrued after the Cost Judgment was entered.