



STORAGE NAME: h6509b.JDC

DATE: 2/19/2018

February 19, 2018

SPECIAL MASTER'S FINAL REPORT

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

Re: CS/HB 6509 - Representative Grant, J.
Relief/C.M.H./Department of Children and Families

THIS IS AN UNOPPOSED EXCESS JUDGMENT CLAIM FOR \$5,076,543.08, BASED ON A JURY VERDICT AWARDING DAMAGES TO C.M.H. FOR PHYSICAL AND SEXUAL ABUSE CAUSED BY THE NEGLIGENT FOSTER PLACEMENT OF A KNOWN SEXUALLY AGGRESSIVE CHILD BY THE DEPARTMENT OF CHILDREN AND FAMILIES ("DCF"). DCF HAS PAID \$100,000 PURSUANT TO SECTION 768.28, F.S.

FINDINGS OF FACT:

Summary

On September 6, 2002, the Department of Children and Families ("DCF") placed J.W.—a ten-year-old foster child with a history of mental illness and sexually aggressive behavior towards younger children—in the home of Christopher and Theresa Hann, who had an eight-year-old son, C.M.H., even though DCF knew of J.W.'s troubling history. Over the next few years, J.W. sexually abused C.M.H. and another four-year-old child who visited the home. J.W. also pulled a knife on C.M.H., squeezed to death C.M.H.'s pet mouse in front of him, and caused a tremendous strain on the Hann family in the midst of Mrs. Hann's stage four cancer diagnosis. The negligent placement of J.W. resulted in the physical, emotional, and sexual abuse of C.M.H. by J.W. To this day, C.M.H. continues to suffer the ill effects of DCF's negligent placement of J.W. in the Hann household.

DCF's placement of J.W. in the Hann home directly contradicted prior recommendations by DCF providers that J.W. should not have unsupervised access to young children, and that his caregivers should be informed about his sexual issues and be able to provide adequate supervision. The placement also departed from DCF's own operating procedures and rules regarding the placement of foster children who have been sexually abused or who are sexually aggressive.¹

The Hanns were not licensed or trained foster parents and had no expertise in providing therapeutic services to a child with pervasive social, emotional, psychological, or psychiatric behavioral problems. Despite DCF's knowledge that J.W. had been sexually abused and sexually abusive towards younger children, DCF failed to provide the Hanns—who shared the home with their own two children—with crucial information regarding J.W.'s psychosocial, behavioral, and sexual history.

Background of J.W. and History of DCF Involvement

J.W. was born in 1992 to a teenage single mother with a history of mental illness and homelessness. She did not receive prenatal care and attempted suicide by inhaling butane during the third month of her pregnancy with J.W.

While in his mother's care and custody, J.W. was subjected to extreme abuse. According to one evaluation, J.W. "had been sexually victimized and abused . . . since approximately age one."² J.W. began to exhibit symptoms of post-traumatic stress disorder ("PTSD") related to his repeated abuse and neglect.

When he was four years old, due to ongoing abuse, J.W. was removed from his mother's home by DCF and placed in foster care. There is evidence in the record that while he was in foster care, J.W. was sexually assaulted by another foster child. At age 5½, J.W. was returned to his mother. He began setting fires—even burning himself on at least one occasion—and intentionally running into the path of oncoming cars. J.W. was diagnosed with psychosis, major depression with psychotic features, adjustment disorder with mixed disorder of conduct and emotion, and attention deficit hyperactivity disorder. He was treated with anti-psychotic medication. After receiving a report that J.W. had again been sexually abused by one of his mother's male friends, DCF placed J.W. back in foster care.

Initial Exhibitions of Sexually Aggressive Behavior by J.W.

After several years, J.W. was returned to his mother. In 2002, at the age of ten, he began to exhibit sexually aggressive behavior towards other children, even to the point of allegedly "perform[ing] anal penetration on [a] neighborhood girl."³

¹ See DCF Operating Procedure 175-88 (Mar. 8, 1999).

² See Chrysalis Center Psychosexual Evaluation of J.W. (Sept. 18, 2003).

³ See *id.*

On June 14, 2002, a Family Services Counselor for DCF ("DCF Counselor") referred J.W. to Camelot Community Care, a DCF provider of child welfare and behavioral health services, for intensive therapeutic in-home services. Realizing the severity of his behavioral and mental disturbances, in a note to Camelot on June 24, 2002, the DCF Counselor noted that J.W. needed to be in a treatment center "ASAP." Camelot agreed to provide in-home mental health services to J.W. as an "emergency temporary solution while DCF [sought] residential placement," concluding that J.W. was "a danger" in the home.

On July 5, 2002, J.W.'s mother informed Camelot that J.W. had engaged in inappropriate sexual behavior with his two-year-old sister. A child safety determination conducted by Camelot on July 12, 2002 found that a sibling was likely to be in danger if J.W. was not supervised. Camelot recommended that J.W.'s parents should keep him separated from younger siblings at night to prevent inappropriate touching and that they should keep an eye on J.W. whenever he interacted with siblings. In August 2002, DCF removed J.W. from his mother's custody after she abandoned her children at a friend's home. J.W. was temporarily sheltered in the home of a family friend.

On August 30, 2002, a Comprehensive Behavioral Health Assessment of J.W. conducted at DCF's request found that J.W.'s issues had begun more than two years earlier and remained generally consistent over time. The assessment concluded that J.W. "should not have unsupervised access to . . . any younger, or smaller children wherever he resides." Crucially, the assessment stated that "[J.W.]'s caregivers must be informed about these issues and must be able to demonstrate that that they can provide adequate levels of supervision in order to prevent further victimization. These issues should be strongly considered in terms of making decisions about both temporary and long term care and supervision of [J.W.]."

Inappropriate Placement with Hanns

On September 6, 2002, the DCF Counselor removed J.W. from his temporary placement with the family friend due to allegations that J.W. had been sexually abused by a member of the household.⁴ He was then immediately placed with Christopher and Theresa Hann.⁵

The Hanns were former neighbors of J.W. and his natural family. The couple lived with their children, including an eight-

⁴ The DCF Counselor apparently failed to report the abuse allegation as required by section 39.201, F.S. (2002). The perpetrator later confessed to and was convicted of child molestation.

⁵ There is no indication in the record that DCF ever sought or obtained court approval for the non-relative placement of J.W. in the Hann home, in apparent violation of DCF's own administrative rule. See Rule 65C-11.004(3), F.A.C. (2002) ("In cases under court ordered supervision, the court must be advised of any plan to place a child with a non-relative and give its approval of such placement").

year-old son, C.M.H. They were not licensed or trained foster parents but had developed a profound empathy for J.W. J.W.'s mother advocated to have him placed with the Hanns.

J.W.'s placement with the Hanns directly contradicted previous recommendations by DCF providers. J.W. was put in a home with an eight-year-old child after DCF had received a warning from Camelot two months earlier that a sibling would be in danger with J.W. The Comprehensive Behavioral Health Assessment completed just one week prior to the placement also recommended that J.W. should not have unsupervised access to younger children. Due to his history of sexual abuse and warnings by DCF providers, DCF was prohibited by its own operating procedures from placing J.W. in a home with a younger child.⁶ Moreover, DCF failed to provide the Hanns with important information regarding J.W.'s background and troubling history of child-on-child sexual abuse.

The Hanns, without knowledge of J.W.'s ongoing inappropriate sexual behavior with younger children, allowed J.W. to share a bedroom with their son, C.M.H. DCF operating procedures explicitly prohibited placing a sexually aggressive child in a bedroom with another child.⁷ The DCF Counselor knew of the planned sleeping arrangements prior to placing J.W. in the Hann home and did not convey the prohibition to the Hanns.

Inappropriate Behavior of J.W. in the Hann Home

Within a few weeks of J.W.'s placement with the Hann family, Mrs. Hann reported to Camelot that J.W. was violently lashing out at her. Camelot recommended to the DCF Counselor that the Hanns place a one-way monitor in the bedroom the boys shared. The DCF Counselor agreed and promised to pass the recommendation along to the Hanns. It is unclear whether the Hanns were ever informed of the recommendation or obtained the monitor.

On October 24, 2002, after having a physical altercation with C.M.H., J.W. pulled a knife on C.M.H. but was prevented from further assaulting C.M.H. by Mr. Hann. Mr. Hann immediately informed Camelot of the incident, and J.W. again underwent a mental health assessment. The DCF Counselor later acknowledged she should have considered removing J.W. from the Hann home at this point in time because of the immediate danger he posed to himself, the Hanns, and C.M.H.

A week later, J.W. engaged in inappropriate sexual behavior with a four-year-old child who was visiting the Hann home. Mrs. Hann reported the incident to DCF. At this time, DCF was again required by its operating procedures to give immediate

⁶ DCF Operating Procedure 175-88.

⁷ Id.

consideration to the safety of C.M.H.⁸ In spite of the inability of the Hanns—who both worked outside of the home—to adequately supervise J.W. and his access to young children, DCF did not remove J.W. from the home.

Camelot began pressuring the DCF Counselor to set up a psychosexual evaluation for J.W.⁹ Camelot reiterated to the DCF Counselor that “[J.W.] needed specific sexual counseling by a specialist in this area.” In the absence of any action by the DCF Counselor, Camelot advised Mr. Hann that a new safety plan would be implemented prohibiting the boys from sharing a room and requiring that J.W. be under close adult supervision when other children were present. Further, Mr. Hann, apparently still without knowledge of J.W.'s extensive history of sexual abuse as a victim and aggressor, informed Camelot that the family disagreed with and would not follow the safety plan.

By November 2002, C.M.H. was exhibiting behavioral problems which Camelot directly attributed to J.W.'s presence in the home. In one school year C.M.H.'s grades dropped significantly. The Hann family, overwhelmed with the number of providers involved in J.W.'s care and the disruption to the family, canceled Camelot's services in December 2002. On its discharge form, signed by the DCF Counselor, Camelot recommended that J.W. be placed in a residential treatment center. DCF did not initiate any change in placement.

In mid-2003, J.W. began expressing sexually inappropriate behavior towards C.M.H. Following escalation in J.W.'s behavior, now directed towards C.M.H., DCF secured a psychosexual evaluation for J.W. The evaluation, dated September 18, 2003, found that J.W.:

- “[F]it[s] the profile of a sexually aggressive child due to the fact that he continues to engage in extensive sexual behaviors and with children younger than himself.”
- “[P]resents a risk of potentially becoming increasingly more aggressive” and “continuing sexually inappropriate behaviors.”
- “[M]ay potentially seek out victims who are children and coerce them to engage in sexual activity.”
- Should receive sexual counseling, and his caregivers should be appropriately trained.¹⁰

In October 2003, the Hann family, feeling unequipped to

⁸ See DCF Operating Procedure 175-88 (“If a . . . child-on-child sexual abuse incident occurred or is suspected to have occurred, immediate consideration will be given to the safety of all children residing in the placement” (emphasis in original)).

⁹ This was something the DCF Counselor should have done earlier pursuant to DCF operating procedures. See *id.* (“If any child in substitute care has been identified as being a victim of sexual abuse or has a history of being sexually aggressive, but has not had a clinical consultation with a professional trained in childhood sexual abuse, a referral will be *initiated* by the assigned family services counselor or their supervisor *within three working days* (of the child being identified)”) (emphasis in original).

¹⁰ The Chrysalis Center Psychosexual Evaluation of J.W. (Sept. 18, 2003).

provide J.W. with the appropriate care, requested that J.W. be placed in a therapeutic treatment facility. Therapeutic placement was authorized for J.W. and he was referred to a care facility. However, the Hanns were told that if J.W. were removed from their home, they might not be able to visit him. This was a source of anguish for the Hanns, who did not want to be the next in a series of parental figures who abandoned J.W. Ultimately, the Hanns decided to keep J.W. in their home and requested additional services to treat his ongoing issues. They also began training to become therapeutic foster parents.

Meanwhile, C.M.H.'s problems at school continued. From late 2003 to early 2004, C.M.H. began to act out and have more conflicts at school. In January 2004, he received a discipline referral for behavioral problems in the classroom. He also gained excessive weight between 2004 and 2006.

Closure of DCF Dependency Case

On March 3, 2004, Theresa Hann was diagnosed with terminal, stage four cancer. In turn, Christopher Hann contacted DCF to stop the process of having J.W. placed with the family as long-term non-relative caregivers and asked that he be placed elsewhere. The DCF Counselor visited the home within 24 hours and said, "We'll get on it."

However, nothing was done, and contrary to the express wishes of the Hanns and without their knowledge, on April 12, 2004, DCF had the Hanns declared as long-term non-relative caregivers of J.W. DCF closed J.W.'s dependency case, leaving him in the care and custody of the Hanns. Because the Hanns were not a part of the foster care system, once DCF closed its dependency case, the Hann family lost approximately 50 percent of the services and counseling that had been provided to the family.

J.W.'s Sexual Abuse of C.M.H.; Removal from Hann Home

The Hanns, left with little support from DCF, grew desperate and more hopeless as they grappled with Mrs. Hann's illness and J.W.'s continuing deviant behavior.

C.M.H.'s troubles also continued. An April 2005 treatment plan noted that C.M.H. had begun to have nightmares and was frustrated at the slightest inconveniences. The treatment plan also indicated that Mrs. Hann's cancer diagnosis and chemotherapy treatments were contributing to C.M.H.'s grief issues and increasing separation anxiety related to his mother. C.M.H. was diagnosed with post-traumatic stress disorder.

In spring 2005, Mr. Hann requested an emergency hearing to move J.W. to residential placement. He explained that although they were doing all they could for J.W., they could no longer cope. He described his wife's diagnosis of terminal cancer and J.W.'s escalating sexual behaviors. Mr. Hann's request was

ignored, and J.W. remained in the Hann home.

A June 16, 2005, Child and Family Connections report noted the following:

- J.W. had a high risk of sexual behavior problems and increasing aggression. He was masturbating excessively, rubbing up against Mrs. Hann, seeking out younger children, lying, and refusing to take responsibility for his actions.
- The Hanns had been told that it was not a matter of whether J.W. would perpetrate on their son again, but a matter of when he would do so.
- J.W. was in need of a more restrictive setting with intensive services specializing in sexual treatment.
- J.W.'s therapists recommended a full-time group home facility specializing in sexual treatment.
- J.W.'s condition was "so severe and the situation so urgent that treatment [could not] be safely attempted in the community."

On or about July 29, 2005, C.M.H., then ten years old, revealed to his parents that about two years earlier, in August 2003, J.W. had forced him to engage in a sex act while the boys were at a sleepover. Mr. Hann demanded that J.W. be removed from the Hann home immediately, and later that day, DCF removed J.W. from the home.

LITIGATION HISTORY:

On April 14, 2006, Christopher and Theresa Hann, individually, and as natural parents and legal guardians of C.M.H., filed a negligence action against DCF, Father Flanagan's Boys' Home, Camelot Care Centers, Inc., and Camelot Community Care, Inc., in the Palm Beach County Circuit Court, based upon the physical, sexual, and psychological abuse of C.M.H. by J.W.

The parties litigated the action for nearly eight years, during which time Theresa Hann passed away from cancer. Shortly before trial, Christopher Hann and C.M.H. settled with Father Flanagan's Boys' Home for \$340,000.

After a four week jury trial in October and November 2013, the jury found that DCF and Christopher and Theresa Hann were each negligent and that such negligence was a legal cause of injury to Christopher Hann and C.M.H. The jury assessed 50 percent of the fault to Christopher Hann and Theresa Hann and 50 percent of the fault to DCF. The jury found no negligence by Camelot Community Care or Father Flanagan's Boys' Home.

The jury determined that total damages to Christopher Hann were \$0 and that total damages to C.M.H. were as follows:

Future Medical Expenses	\$ 250,000.00
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Lost Earning Ability	\$ 250,000.00
Past Pain & Suffering	\$ 6,000,000.00
Future Pain & Suffering	\$ 3,500,000.00

TOTAL DAMAGES \$ 10,000,000.00

Reduced to reflect DCF's proportionate share of 50 percent liability, a final judgment was entered against DCF for \$5,000,000 (including post judgment interest¹¹) on November 8, 2013. The court entered a final cost judgment for \$176,543.08.

DCF appealed the final cost judgment to the Fourth District Court of Appeal. The appeal was dismissed on March 10, 2014. No further appeals were taken, and the time for appellate review has expired. DCF has paid \$100,000 of the final judgment pursuant to the cap on liability imposed by section 768.28, F.S.

CLAIMANT'S POSITION:

Claimant asserts Respondent was negligent and directly liable for the injuries suffered by C.M.H. as a result of sexual abuse due to placing J.W., a known sexually aggressive child, in the Hann home and failing to remove J.W. when Respondent was aware that placement was inappropriate and dangerous.

RESPONDENT'S POSITION:

Respondent does not oppose the claim bill and requests that any amount awarded be taken from the General Revenue Fund.

CONCLUSIONS OF LAW:

Regardless of whether there is a jury verdict or a settlement agreement, each claim bill is reviewed *de novo* in light of the standard elements of negligence.

Duty & Breach

I find that DCF breached the following duties:

- The duty to provide the Hanns, as caregivers of J.W.—a known child sexual aggressor—with written, detailed, and complete information of J.W.'s history to help prevent the reoccurrence of child-on-child sexual abuse. This breach violated Florida law and DCF operating procedures.¹²
- The duty to exercise reasonable care when placing J.W., a child aggressor involved in child-on-child sexual

¹¹ Since DCF cannot pay this claim until the claim bill becomes a law, it is generally legislative policy not to award post-judgment interest.

¹² See s. 409.145(7), F.S. (2002) ("Whenever any child is placed by the department in a shelter home, foster home, or other residential placement, the department shall make available to the operator of the shelter home, foster home, other residential placement, or other caretaker as soon thereafter as is practicable, all relevant information concerning the child's demographic, social, and medical history"); Rule 65C-13.015, F.A.C. (2002) ("Caregivers must be given detailed and complete information so they can understand the circumstances of the maltreatment in order to avoid an unwilling replication of those circumstances"); DCF Operating Procedure 175-88 (stating that caregivers must be provided with "written, detailed and complete information related to sexual abuse victims and aggressors placed with them so they can prevent the reoccurrence of child-on-child sexual abuse incidents").

abuse and sexual assault, with the Hanns. DCF breached this duty and violated its own operating procedures when it placed J.W. with the Hanns in spite of specific recommendations by DCF providers that J.W. should not have access to young children.¹³

- The duty to ensure the Hanns were properly trained and equipped to meet J.W.'s serious needs, which DCF breached in contravention of its own policies.¹⁴
- The duty to establish appropriate safeguards and strategies to provide a safe living environment for all children living in the Hann home with J.W., a child sexual aggressor. DCF breached this duty most notably by allowing a situation where C.M.H. and J.W. shared a bedroom.¹⁵
- The duty to exercise reasonable care, as appropriate under the circumstances, during crucial time periods after J.W. was placed with the Hanns. DCF breached this duty most notably when it failed to remove J.W. from the Hann home after it had become clear that the placement was inappropriate and dangerous to C.M.H.

Causation

I find that the sexual, physical, and emotional abuse suffered by C.M.H. was the direct and proximate result of DCF's failure to fulfill its duties relating to a known sexually aggressive child.

Damages

I find that the amount of damages for \$5,000,000 is reasonable under the circumstances and supported by the evidence. C.M.H. was diagnosed with PTSD in 2005, and the diagnosis was reaffirmed in 2011. The psychological report indicated that contributing factors to the PTSD were "the sexual abuse and extended mental anguish associated with said abuse" and issues related to C.M.H.'s mother's cancer diagnosis. In 2006, C.M.H. was seen for encopresis, a condition involving fecal incontinence. He also underwent a psychiatric evaluation which found that he had serious temper issues and anxiety.

C.M.H. was reevaluated by Dr. Stephen Alexander in October

¹³ See DCF Operating Procedure 175-88 ("Older sexual abuse victims shall not be placed with younger children, if treatment agents or therapists indicate in writing that it is not safe to do so"); Comprehensive Behavioral Health Assessment of J.W. at 11 ("In view of [J.W.]'s recent sexual acting out behavior with his younger sister, [J.W.] should not have unsupervised access to her, or to any younger, or smaller children wherever he resides").

¹⁴ See DCF Operating Procedure 175-88 ("Substitute caregivers for sexually abused and sexually aggressive children must be given specific information and strategies to provide a safe living environment for all of the children living in their home") (emphasis in original); Comprehensive Behavioral Health Assessment of J.W. at 11 ("[J.W.]'s caregivers must be informed about these issues and must be able to demonstrate that they can provide adequate levels of supervision in order to prevent further victimization").

¹⁵ See DCF Operating Procedure 175-88 ("[Every] effort must be made to place sexually aggressive children in homes where there are no other children. A sexually aggressive child shall never be placed in a bedroom with another child") (emphasis in original).

2014. Dr. Alexander found that C.M.H. suffers from PTSD and major depression. Dr. Alexander stated C.M.H.'s psychological trauma was caused by the illness and death of his mother and J.W.'s presence in the home (including J.W.'s general disruptive presence and J.W.'s sexual inappropriateness towards C.M.H.).

A life care continuum, formulated by Comprehensive Rehabilitation Consultants, Inc., to determine the funds necessary to provide for the counseling and support C.M.H. needs, determined that the cost for medical care, psychotherapies, educational and support services, transportation, and housing, would total \$1,881,010.22 over C.M.H.'s life.

ATTORNEY'S/
LOBBYING FEES:

Claimant's attorneys have agreed to take a fee of 25 percent of Claimant's total recovery. Of that percentage, 22 percent will be allocated as attorneys' fees, and 3 percent will be allocated as lobbyists' fees.

LEGISLATIVE HISTORY:

This is the fourth session this claim has been presented to the Legislature. Last session, CS/CS/HB 6525 (2017) passed the House by a vote of 112-4 but died in Senate Appropriations.

RECOMMENDATION:

Accordingly, I recommend that Committee Substitute for House Bill 6509 be reported **FAVORABLY**.

Respectfully submitted,

JORDAN JONES

House Special Master

cc: Representative James Grant, House Sponsor
Senator Braynon, Senate Sponsor
Tom Cibula, Senate Special Master