NOT DESIGNATED FOR PUBLICATION

STATE OF LOUISIANA

COURT OF APPEAL

FIRST CIRCUIT

2006 CA 0607

TRAVIS STEWART, INDIVIDUALLY AND ON BEHALF OF
HIS DECEASED MINOR CHILD, MYA GEORGE

VERSUS

STATE OF LOUISIANA THROUGH DEPARTMENT OF
SOCIAL SERVICES

Judgment Rendered: MAR 26 2008

* * * *

Appealed from the
Eighteenth Judicial District Court
In and for the Parish of West Baton Rouge
State of Louisiana
Docket Number 33607

Honorable Alvin Batiste, Jr., Judge

* * * *

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BEFORE: CARTER, C.J., WHIPPLE, PARRO, KUHN, GUIDRY,
PETTIGREW, DOWNING, GAIDRY, McDONALD, McCLENDON, HUGHES,
AND WELCH, JJ.

Kuhn, J. Dissents, adopts the dissent of Parro, J + assigns additional reas:
McClendon J. Concurs in part and Dissents in part and assigns reasons.
Pettigrew J. Concurs.
Parro, J., dissents and assigns reasons.
McDonald, J. dissents for the reasons assigned by Judge Parro.

PER CURIAM

The State of Louisiana, through the Department of Social Services, Office of Community Services (DSS), appeals a judgment in favor of a biological father in a survival action for fatal injuries sustained by his minor daughter while she was the subject of an investigation by DSS. For the following reasons, we amend the judgment, and as amended, affirm.

FACTS AND PROCEDURAL HISTORY

On April 11, 2003, two-and-a-half-year-old Mya George (Mya) was taken to the hospital by ambulance for treatment of a head injury, a subdural hematoma that caused her to have seizures and placed her in a coma. Mya's biological parents were Melissa Turnage (Turnage) and Travis Stewart (Stewart). Mya lived with her mother and rarely saw her father. Jessie White (White), Turnage's stepfather, was caring for Mya when she sustained the injury to her head. On April 14, 2003, DSS received a referral from the hospital concerning Mya. This matter was assigned to DSS caseworker Ruby Jenkins (Jenkins). When subsequently interviewed by Jenkins, White denied having abused Mya. White reported that Mya's older sister, Rheanna Turnage (Rheanna), who suffered from Downs Syndrome, hit Mya in the head with a toy. Because the injury had been sustained while Mya was in White's care, Turnage was instructed not to allow White to be a caregiver for the children during the investigation of this matter by DSS. DSS was unable to definitively determine what caused Mya's injury, and Mya was allowed to remain in Turnage's custody when she was discharged from the hospital.

On May 22, 2003, Mya's sitter, Melissa Smith (Smith), reported to DSS and the police that Mya had bruises on her upper, middle, and lower back and her buttocks and that she had a patch of hair missing from her head. Smith noted that Mya and Rheanna were dirty and "unkept" and had been in the care of White. Based on this report and an initial investigation by Jenkins, DSS obtained a verbal

hold order from a district court judge to remove both children from Turnage's custody.

The following day when Jenkins and a co-worker, Chris Butler (Butler), appeared for what they believed was to be the 72-hour hearing that follows the issuance of a verbal hold order in cases of this nature, they were advised that the judge wanted to speak with them. During their meeting, the judge indicated that the verbal hold order was going to be vacated because of his relationship to Turnage. After informing them that this matter could be brought before another judge, the issuing judge requested that they meet with Turnage and attempt to work the matter out. The judge offered the use of his library as a meeting place. Jenkins and Butler met with Turnage to discuss the issue of childcare. Turnage suggested that her friend, Kimberly Delane (Delane), be allowed to care for the children while she worked. A safety plan was prepared, which contemplated that Delane would be the caregiver of Mya and Rheanna in Turnage's absence and provided that White would not be a caregiver for the minor children. In an interview with Jenkins later that day, Delane agreed to care for and supervise the children while Turnage was at work.

DSS's investigation of the April and May incidents continued over the next few weeks during which time Jenkins conducted interviews and gathered medical records. The case was staffed by DSS on June 27, 2003. The results of the investigation led to the following conclusions: the April incident was due to a lack of supervision, but was inconclusive for physical abuse as DSS could not determine how the injury occurred and who may have been involved; and the May incident was due to physical abuse and a lack of supervision. DSS informed Turnage of the results and again notified her that White was not to be used as a caregiver for the children since Mya's injuries occurred while she was in his care.

On September 23, 2003, Turnage took an unresponsive Mya to the hospital with bruises on her head, forehead, arms, eyes, ears, back, shoulders, and lower legs. Mya also had a lump on top of her head, hematomas on her forehead, abrasions and scratches to both thighs and the face, and a skin tear on her buttock. Local authorities informed DSS that Mya was in a coma and was not expected to live due to a beating by White. Mya died on September 25, 2003. She was three years old.

In light of these circumstances, Stewart filed survival and wrongful death actions against DSS. Following a trial by jury, he was awarded $8,000,000 on behalf of Mya for the survival action and $0 for his wrongful death action. Fault was assessed 75 percent to DSS, 20 percent to Turnage, and 5 percent to White.[1] The trial court denied DSS's motion for a judgment notwithstanding the verdict and/or, in the alternative, a motion for new trial.[2] DSS appealed, contending that the jury erred in finding DSS to be grossly negligent in the handling of the investigation of Mya's case, in finding DSS to be 75 percent at fault, and in awarding $8,000,000 in damages in the survival action.

APPLICABLE LAW

The duty of a child protection caseworker and DSS is delineated by La. Ch.C. arts. 611 and 612 and La. R.S. 9:2798.1. Todd v. State, through Department of Social Services, Office of Community Services, 96-3090, p. 8 (La. 9/9/97), 699 So. 2d 35, 39. At the time pertinent to this case, La. Ch.C. art. 611(A) provided as follows with respect to immunity from liability afforded to a DSS caseworker:[3]

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[1] The judgment simply cast DSS for 75 percent of the judgment amount, plus judicial interest from the date of judicial demand and its share of court costs.

[2] In his memorandum in opposition to DSS's motions, Stewart indicated that the verdict was reduced by operation of law because of the statutory cap of $500,000.

[3] Article 611 was amended by 2004 La. Acts, No. 76, § 1, which rewrote paragraph A, and by 2006 La. Acts, No. 372, § 1, which added paragraph C.

> Any person who in good faith makes a report, cooperates in any investigation arising as a result of such report, or participates in judicial proceedings authorized under the provisions of this Chapter, or any caseworker who in good faith conducts an investigation, makes an investigative judgment or disposition, or releases or uses information contained in the central registry for the purpose of protecting a child, shall have immunity from civil or criminal liability that otherwise might be incurred or imposed.

DSS's investigation and assessment of a report of abuse is governed by La. Ch.C. art. 612, which provides:

> A. (1) Upon receiving a report of abuse or neglect of a child who is not in the custody of the state, the local child protection unit of the department shall promptly assign a level of risk to the child based on the information provided by the reporter.
>
> (2) Reports of high and intermediate levels of risk shall be investigated promptly. This investigation shall include a preliminary investigation as to the nature, extent, and cause of the abuse or neglect and the identity of the person actually responsible for the child's condition. This preliminary investigation shall include an interview with the child and his parent or parents or other caretaker. Admission of the investigator on school premises or access to the child in school shall not be denied by school personnel.
>
> (3) In lieu of an investigation, reports of low levels of risk may be assessed promptly through interviews with the family to identify needs and available match to community resources. If during this assessment, it is determined that a child is at immediate substantial risk of harm, the local child protection unit shall promptly conduct or participate in an intensive investigation.
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> B. All persons, including without limitation mandatory and permissive reporters, shall cooperate fully with investigative procedures, including independent investigations and psychological evaluations of the child initiated by the parent on behalf of the child. The provisions of this Paragraph shall not require the disclosure of any communications between an attorney and his client or any confession or other sacred communication between priest, rabbi, duly ordained minister, or Christian Science practitioner and his communicant.
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> C. All interviews of the child or his parents conducted in the course of a child protective investigation shall be tape-recorded, if requested by the parent or parents.
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> D. Upon determination that there is reason to believe that the child has been abused or neglected, the local child protection unit shall conduct a more intensive investigation. If necessary, the investigator may apply for an evaluation order authorized by Article 614.

> E. When the report concerns a facility under the supervision of the department, the secretary of the department may assign the duties and powers enumerated herein to any office within the department to carry out the purposes of this Chapter or may enter into cooperative agreements with other state agencies to conduct investigations in accordance with this Article.
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> F. Violation of the duties imposed by this Article subjects the offender to criminal prosecution authorized by R.S. 14:403(A)(2).
>
> G. The Department of Social Services shall set priorities for case response and allocate staff resources to cases identified by reporters as presenting immediate substantial risk of harm to children. Absent evidence of willful or intentional misconduct or gross negligence in carrying out the investigative functions of the state child protection program, caseworkers, supervisors, program managers, and agency heads shall be immune from civil and criminal liability in any legal action arising from the department's decisions made relative to the setting of priorities for cases and targeting of staff resources.

The duty to investigate complaints of child abuse or neglect is not tantamount to insuring the safety of children. White v. White, 479 So. 2d 588, 589 (La. App. 1st Cir. 1985).

Concerning the policymaking or discretionary acts or omissions of public entities or their officers or employees, La. R.S. 9:2798.1 in pertinent part provides:

> B. Liability shall not be imposed on public entities or their officers or employees based upon the exercise or performance or the failure to exercise or perform their policymaking or discretionary acts when such acts are within the course and scope of their lawful powers and duties.
>
> C. The provisions of Subsection B of this Section are not applicable:
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> (1) To acts or omissions which are not reasonably related to the legitimate governmental objective for which the policymaking or discretionary power exists; or
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> (2) To acts or omissions which constitute criminal, fraudulent, malicious, intentional, willful, outrageous, reckless, or flagrant misconduct.

Thus, although DSS and its employees may be entitled to the qualified immunity set forth in La. Ch.C. arts. 611 and 612 and La. R.S. 9:2798.1, there is no such immunity if gross negligence is alleged and proven. C.R.W. v. State of Louisiana,

Department of Social Services, Office of Community Services, 05-1044, p. 10 (La. App. 1st Cir. 9/1/06), 943 So. 2d 471, 481, writ denied, 06-2386 (La. 12/21/06), 944 So.2d 1289.

Decisions involving the removal of a child from his home clearly lie within the scope of the duty and authority of social workers. Such decisions require personal deliberation and judgment. Although provided with guidelines, social workers are not merely performing a duty in which they are given no latitude for action. The manner in which the investigation is conducted is one of discretion, unless the investigation is so incomplete that it could not be found to be thorough. Todd, 96-3090 at 14, 699 So. 2d at 42. The supreme court recognized the awkward balance that child abuse cases present to caseworkers, i.e., the need for delicate handling while yet looking out for the best interest of the child. Todd, 96-3090 at 15, 699 So. 2d at 43.

Stewart urges that DSS's investigation was not thorough and that the decisions reached were anything but reasonable given the circumstances. He contends that DSS's investigation was so incomplete that it cannot be found to be thorough, as substantiated by Jenkins' testimony regarding the following failures: to document Mya's hospitalization; to speak with Mya about her abuse; to speak with Mya's treating physician after her hospitalization; to retrieve the plastic hammer that was allegedly used to inflict Mya's head injury in April 2003; to document that White was the subject of a confirmed incident of abuse and therefore posed a danger to Mya; to seek professional assistance to speak with Mya about her abuse; to seek a protective order against White for Mya's safety; to interview Rheanna about the April 2003 incident; to monitor Mya's safety after discharge from the hospital and her being returned to her former environment following the April 2003 incident; and to search out other family members who were suitable to care for Mya.

In considering Stewart's argument, we are mindful that Stewart has the burden of proving gross negligence on the part of Jenkins in order to recover in this matter. Gross negligence is the "want of even slight care and diligence" and the "want of that diligence which even careless men are accustomed to exercise." Ambrose v. New Orleans Police Department Ambulance Service, 93-3099, p. 5 (La. 7/5/94), 639 So. 2d 216, 219-20. Gross negligence has also been termed the "entire absence of care" and the "utter disregard of the dictates of prudence, amounting to complete neglect of the rights of others." Todd, 96-3090 at 10, 699 So. 2d at 40. Additionally, gross negligence has been described as an "extreme departure from ordinary care or the want of even scant care." Todd, 96-3090 at 10, 699 So. 2d at 40. There is often no clear distinction between such willful, wanton, or reckless conduct and gross negligence, and the two have tended to merge and take on the same meaning. Todd, 96-3090 at 10, 699 So. 2d at 40, (citing Falkowski v. Maurus, 637 So. 2d 522, 528 (La. App. 1st Cir. 1993)). Gross negligence, therefore, has a well-defined legal meaning distinctly separate and different from ordinary negligence. Ambrose, 93-3099 at 6, 639 So. 2d at 220. The jury's determination that Jenkins' conduct in this case constituted gross negligence is subject to review under the manifest error-clearly wrong standard. See Ambrose, 93-3099 at 13, 639 So. 2d at 223. In determining if the jury's finding in this regard was manifestly erroneous, it is necessary to assess each incident and the information known to Jenkins at such time.

DSS's Investigation

At the time of trial, Jenkins had worked as a child welfare specialist II for 15 of the 16 years that she had been employed with DSS. Her job was to investigate reports of abuse or neglect that had been reported to the agency.

On April 11, 2003, Mya was admitted to the hospital with a new onset seizure disorder and a subdural hematoma secondary to a closed head injury. The

medical records of Our Lady of the Lake Regional Medical Center (OLOL) reflect the following pertinent facts. The hospital social worker, Maria Cashio (Cashio), noted that Mya and Rheanna had been with White for the past two weeks and had not seen the babysitter;[4] Dr. Katherine Elkins, Mya's regular pediatrician, and Dr. Michael Quinn, Dr. Elkins' medical partner, cared for Mya while she was in the hospital. To rule out an ocular injury or trauma, Dr. Christopher P. Grenier, an ophthalmologist, was consulted. According to Dr. Grenier, Mya's ocular exam was completely normal and atraumatic at that time. However, in the discharge summary dictated by Dr. Quinn, he stated that "[o]phthalmology was consulted which showed no signs of child abuse." A pediatric neurology consult by Dr. Barbara J. Golden was also performed on Mya during her hospitalization. Dr. Golden observed that "[t]here is questionable history of trauma and the child has also been noted to have some lesions on her feet, as well as a lesion on the left side of her head."[5] Mya was transferred out of the hospital's intensive care unit to the regular hospital floor on April 14, 2003.

Pursuant to a consultation ordered by one of Mya's treating physicians, Cashio contacted DSS on April 14, 2003, regarding the possibility of physical abuse based on the presence of the subdural hematoma. This report of abuse was assigned to Jenkins. Cashio's records indicated that she had spoken to different doctors who had treated Mya and that they could not say that the subdural hematoma was a direct result of someone purposefully hitting Mya in the head. It was determined that the injury could have possibly happened the way it had been reported, that is, that Rheanna had hit Mya on the head with a toy xylophone hammer.

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[4] The Whites had separated, and Mrs. White had been living with her mother since April 2003.

[5] Jenkins received Mya's medical records from OLOL on June 6, 2003, pursuant to a medical authorization executed by Turnage.

When Jenkins called the hospital to speak to Turnage, Smith, who was caring for Mya while Turnage worked,[6] spoke with Jenkins. According to Smith, during this conversation, she asked Jenkins why she had not been contacted before now. Jenkins testified that she had not received any complaints concerning Mya from anyone prior to April 14, 2003, and that this was the first time that Jenkins had ever talked to Smith. During their conversation, Smith informed Jenkins that she was willing to care for Mya and Rheanna.

Smith testified that she began babysitting for Mya and Rheanna in September 2002. Initially, her hours were from nine to five, and Turnage would pick up the children from Smith's home at the end of Turnage's work day and bring them back to Smith the next morning. After about a month, the children began staying with Smith overnight for days at a time.[7] Sometimes, Rheanna would leave, and Mya would stay. Subsequently, White started picking up both girls from Smith's home. Smith testified that she loved Mya and Rheanna like her own children. According to Smith, Stewart visited Mya at her home a couple of times. These visits were arranged by Turnage, who told Smith to allow Stewart to visit with Mya, but not to let Mya leave with him. Smith testified that Mya knew Stewart and called him daddy.

Smith stated the children were always dirty and sick when delivered to her by White. Over time, things worsened. Smith explained that in the beginning of 2003, the children would arrive at her home with bruises, scrapes, blisters, and black eyes. Smith testified that she observed a change in their personalities as well. Because the situation was eating away at her, Smith at some point got her

[6] Smith stayed with Mya for two days and one night in the hospital. According to Smith, Mya did not speak much during this time.

[7] There were times when Smith kept Rheanna for up to four days at a time. Once, Mya was left with Smith for a whole month.

next door neighbor, Misty Porche (Porche), involved.[8] Porche testified she noticed that Mya started to act withdrawn in that she would no longer speak or go swimming with her daughter.

According to Smith, she contacted the Plaquemine office of child protective services several times, but received no response;[9] however, she did not attempt to get Stewart, his mother--Gertrude Beverly (Beverly),[10] or the police involved. Once, after White had delivered the children to Smith, Smith contacted Turnage at work to come see the children. Smith threatened to call the authorities if Turnage did not come. After seeing the children, Turnage called her mother, Sheila White, who in Smith's opinion always had some bogus excuse to explain the condition of the children.[11] According to Smith, Turnage, as usual, let it go at that and returned to work.

After contacting Smith in Mya's hospital room, Jenkins told Smith to have Turnage call her. Later that day, Jenkins spoke to Turnage on the telephone for approximately one-and-a-half to two hours. Turnage reported that she was a single parent who had to work to make ends meet.[12] Jenkins learned that Turnage had a sitter for the children but had been unable to afford to pay a $300 debt owed to

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[8] While at Smith's home, Mya sometimes played with Porche's young daughter. Porche recalled that when she first met Mya, she was just starting to speak.

[9] Porche testified that she was present when Smith called DSS a couple of times. She added that she herself had talked to DSS a couple of times. Porche indicated that she had called DSS twice from Smith's home because Smith had not been able to get anyone to return her calls.

[10] At trial, Smith stated that she did not have contact information for Stewart or Beverly.

[11] Smith stated that she was always given the excuse that the children had fought, but only one child had marks. Furthermore, Smith noted that Rheanna was not an aggressive child and that Rheanna was very loving toward Mya.

[12] Cashio's notes reflect the following: Turnage worked as a cashier for a convenience store; Mya and Rheanna were cared for by White or a babysitter while Turnage worked. Mrs. White testified that although she lived with her mother, she visited White's home daily.

Smith for past childcare.[13]

Turnage told Jenkins that one-and-a-half to two weeks prior to the hospitalization, she was aware that something had happened to Mya while in White's care.[14] According to Turnage, the only known hit to Mya's head occurred when Rheanna hit Mya on the head with a toy xylophone. Turnage stated that she checked Mya, but found no injury of concern. Jenkins visited Mya at the hospital the next day. Jenkins admitted that DSS policy required a case worker to speak with a doctor during the course of an investigation. Although none of Mya's treating physicians were available on the day Jenkins visited the hospital, at no other time during the course of the investigation did Jenkins speak with Mya's physicians. Jenkins also did not interview Mya in connection with this incident. Jenkins said she did not interview Mya due to Mya's age; yet Mya was asleep when Jenkins visited her in the hospital, so Jenkins did not know Mya's verbal abilities and she never did anything more to find out if Mya could tell her what happened. Due to Rheanna's inability to give a statement, Jenkins made no effort to interview Rheanna about this incident.

Jenkins called Cashio the next morning to inform her that she had spoken to Turnage and had visited the hospital. Jenkins reported that her investigation was incomplete. Jenkins noted that although no one had reported seeing White purposefully hit Mya, Turnage was advised not to allow White to care for Mya or Rheanna while the investigation was being conducted. On April 16, 2003, Cashio called Jenkins to inform her that Mya was ready for discharge. Jenkins authorized the hospital to discharge Mya to Turnage's care. Cashio testified that once a report

[13] According to Smith, Turnage's payment for childcare fluctuated depending on her ability to pay. After a period of time, Smith was not really concerned with the money and did not care that Turnage was behind in payments.

[14] Turnage told Cashio that Mya and Rheanna had been staying with White for the previous two weeks.

is made to DSS concerning suspected child abuse, the child cannot be released from the hospital without authorization from DSS. Notably, Jenkins did not devise a family emergency plan at this time, despite Turnage's statement that she did not have anyone other than White to help her with the children while she worked. Mya left the hospital on April 17.

In connection with her investigation of the April incident, Jenkins interviewed the Whites on April 21, 2003, at her office, at White's request. White told Jenkins that he had no knowledge of an injury that may have occurred on April 11, while Mya and Rheanna were in his care, but he recalled that while he was in the bathroom a week and a half earlier, Rheanna had hit Mya on the head with a toy xylophone hammer. When he got out of the bathroom, he observed that Mya was crying and that Rheanna had a hammer in her hand. Thus, White assumed that Rheanna had hit Mya. At that time, he noticed no visible sign of injury.

Jenkins had investigated Turnage in connection with a fracture to Rheanna's leg in September 1997, that occurred while Rheanna was in White's care, and based on a validated finding of neglect, DSS had advised Turnage that White could not provide unsupervised care for Rheanna. Nonetheless, Turnage was allowed to take the children, despite Turnage's own admission that it seemed impossible for her to work without White caring for her children. The prior incident with Rheanna had already demonstrated to Jenkins that given an opportunity, Turnage was not going to comply with a safety plan devised by DSS, which required Turnage not to allow White to care for her children.

Although Jenkins had determined that Smith was available to assist Turnage by providing childcare after Mya's April hospitalization, Smith testified that Turnage began to shut her out. Following Mya's discharge, Jenkins did not make a

home visit and admitted that she did not know who was watching the children while Turnage worked.

On May 22, 2003, Turnage left Mya and Rheanna with Smith, who observed bruises on various portions of Mya's body and that Rheanna appeared to be unbathed and her hair unwashed and uncombed. Troubled by these observations, Smith called DSS to report the condition of the children. When Smith did not receive a return phone call from DSS, she called Porche to come see the children. On viewing the children, Porche also called DSS, but did not receive a return phone call. Porche subsequently went to a local store where she encountered Office Leo Fontenot, whom she told about Mya and Rheanna. Porche asked Officer Fontenot to come see the children, which he did. Officer Fontenot then contacted Detective Kenneth Young, who interviewed Smith and Porche and reported the situation to DSS.

Smith stated that Turnage had dropped the kids off and left quickly due to an emergency at the hospital with her mother. She stated that Turnage had also told her that she had just picked the children up from White. According to Detective Young, Smith indicated that she suspected that White was responsible for the bruises on Mya. Smith informed Detective Young that she was concerned about the children since she had been noticing bruises on Mya over the last five months.

Jenkins testified that on May 22, Smith left a voice message on the telephone of one of Jenkins' co-workers while she was out of the office.[15] Jenkins said she returned Smith's call around noon after retrieving Smith's telephone number from her co-worker. While speaking with Smith, Jenkins received a call from Detective Young, who confirmed Smith's story. Detective Young, who was very concerned for the children, then took Smith and the children with him to the

[15] Smith testified that she called DSS two or three times on May 22 before getting the sheriff's office involved.

police station where Jenkins met them. Jenkins spoke with Detective Young, who had initiated the investigation, and interviewed Smith, who denied having abused Mya. Smith reported that Turnage had dropped the children off at her home because of a crisis with Mrs. White. Smith was willing to care for Mya.

While they were at the police station, Jenkins took pictures of the children and interacted with them. Although Mya was able to speak some words, Jenkins said Mya was unable to communicate to the extent that Jenkins could get a clear concise statement from her; therefore, Jenkins did not get a statement from Mya concerning her injuries. She only asked Mya who hurt her, the response to which is not contained in the record.

Being unable to locate Turnage and after consulting with her supervisor, Jenkins contacted the office of a district court judge in the Eighteenth Judicial District that generally handled DSS matters for West Baton Rouge Parish in an effort to obtain a verbal hold order authorizing her to take Mya and Rheanna into state custody.[16] Jenkins spoke to the judge, who was out of the office, on his cell phone. After being advised of the facts, the judge granted a verbal hold order. Jenkins testified that she later spoke to the judge's law clerk who indicated that the judge's next court date was the following morning. According to Jenkins, the law clerk advised her to be there for 9:00 a.m. The children were taken into state custody and then brought by Jenkins to Dr. Elkins for an examination. In addition to the bruises, Dr. Elkins discovered that Mya had a right ear infection with a hole in her eardrum. Her diagnosis was a non-accidental trauma. Afterwards, Jenkins placed the children into foster care.

Upon returning to her office, Jenkins prepared the paperwork for the hearing that was supposed to take place the next day. When Jenkins and Butler, the foster

[16] Although Jenkins was aware of Mya's father's name as a result of the conversation that she had with Turnage on April 14, 2003, Jenkins did not have any other identifying information. Thus, no effort was made to contact him at this point.

care case manager assigned to the case, showed up for what they believed would be the 72-hour hearing,[17] Jenkins and Butler were told that the judge who had issued the verbal hold order wanted to see them in his chambers. Turnage, her brother, Joseph George (George), and her grandmother (Verda Sanchez) were sitting in the outer area of the judge's chambers while Jenkins and Butler met with the judge.[18] The judge advised Jenkins and Butler that he had to rescind the verbal hold order.[19] He explained that he was related to Turnage and that he should not have issued the verbal hold order. The judge then noted that DSS could request a hold order from another district court judge. Despite his request that Jenkins and Butler talk with Turnage, the judge said that he did not order DSS to return the children to Turnage because he believed the stated grounds were sufficient to justify the issuance of the hold order.

In spite of being specifically told by the judge that she could request a hold order from another judge, Jenkins did not pursue another hold order. Jenkins' immediate supervisor, Robin Bettis (Bettis), a child welfare district manager with DSS, explained that DSS did not agree with the decision to vacate the verbal hold order in that the agency recommendation was continued custody with the state. According to Bettis, a presiding judge frequently asks DSS to work with a family. Bettis explained that when a request of this nature is received from a judge, DSS

[17] The issuing judge testified that the children and their parents were not there on May 23, 2003, for the 72-hour hearing. He explained that DSS had to present an affidavit verifying everything within 24 hours of the issuance of the hold order to get the hold order produced in writing. An affidavit was presented by DSS, but it was not notarized due to his realization that a conflict of interest existed.

[18] According to the issuing judge, Turnage's presence on May 23 was pure coincidence, while Jenkins' case notes reflect that she informed Turnage that the 72-hour hearing would be conducted on that day at 9:00 a.m.

[19] Candice LeBlanc, DSS attorney supervisor for most of the state, testified that DSS has to abide by an order by a judge vacating a hold order. Jenkins' immediate supervisor, Robin Bettis, explained that once the hold order was vacated, the state no longer had legal custody of the children.

would generally not go to a different judge in an effort to have its recommendation adopted.

On May 23 while in the judge's library, Turnage could not explain how Mya sustained her injuries. During their two-hour meeting, Jenkins talked with Turnage while Butler made contact with different community resources in an effort to set up appointments to assist Turnage in utilizing available services. The parties discussed daycare options and the possibility of another person who could safely provide care for the children. Jenkins made it clear that White could not under any circumstances care for the children. The state was willing to pay for daycare services; however, Turnage's work hours at the convenience store varied from 2:00 p.m. to 2:00 a.m. or 2:00 a.m. to 10:00 a.m. There were no daycare facilities in West Baton Rouge Parish that provided services for those work shifts. Jenkins and Butler suggested that Turnage look into 24-hour daycare services available in Baton Rouge, but Turnage had a problem with transportation. Furthermore, there were no special needs daycare centers in West Baton Rouge Parish. Turnage was provided with information on all of the available community resources and was offered counseling on appropriate parenting. Turnage mentioned that she had spoken to her friend Delane about helping with the care of her children.

Upon leaving the judge's office, Jenkins contacted the foster parents and asked that the children be brought to a particular fast food restaurant. After getting the children, Jenkins transported them home to their mother where Jenkins met and interviewed Delane. Delane indicated that she was going to care for the children in Turnage's home. Later that evening, Turnage's brother called Jenkins to inform her that Turnage had discovered a knot on Mya's shoulder when she was removing Mya's clothing. He indicated that they were going to bring Mya to the hospital. The attending physician suspected a fracture of her right clavicle. The hospital records of this visit indicate that Mya's language consisted of only a few words.

When Jenkins was asked about the release of Mya by the hospital, Jenkins authorized the medical personnel to release Mya to her mother's care. Jenkins visited Mya at Turnage's home again later that night.

In connection with her investigation of the May 22 incident, Jenkins attempted to speak to White on May 30, but White would not let her into his home. Nonetheless, Jenkins did not suspect that Mya and Rheanna were at White's home at that time. Jenkins next visited Turnage's home. Turnage and Jenkins spoke outside. During this meeting, Jenkins saw the children with a teacher who worked with Rheanna at Turnage's home.

Smith testified that after the May 22 incident, Turnage would not bring the children to her home because Turnage felt that Smith was causing problems.[20] In an effort to visit with the children, Smith went to Turnage's home a couple of times. According to Smith, White was at Turnage's home the first time she visited around May 30. Smith indicated that she wanted to take the children, but Turnage refused. Upon leaving Turnage's home, Smith reportedly telephoned Jenkins to let her know that White was staying at Turnage's residence. Jenkins denied that she spoke to Smith about the children being with White around May 30.

On June 2, 2003, Beverly contacted Jenkins and expressed concern that someone was mistreating Mya.[21] Beverly offered to have Mya placed in her home.[22] Jenkins obtained Beverly's home telephone number, address and where

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[20] Nonetheless, Smith testified that Stewart shot fireworks with Mya at her home around July 4th.

[21] Beverly testified that in May 2003, while she was in a store, Ray Bryant of the West Baton Rouge Parish juvenile department informed her that Mya had a broken collar bone as a result of being abused. That same day, Beverly approached Turnage at her place of work and inquired about Mya. Turnage responded that Mya was fine. Afterwards, she went by the office of the judge who had issued the verbal hold order in search of guidance. Upon being told that she was interested in getting Mya, the judge's secretary called the person to whom she needed to speak and gave her the telephone. Beverly told the person to whom she was speaking about her relationship to Mya and pleaded for Mya to be given to her. After giving this person her contact information, Beverly waited for someone from DSS to contact her, but no one ever did.

[22] Jenkins never heard from Stewart regarding Mya.

she was employed. According to Beverly, she and her son at one time had contact with Mya but not any longer. Jenkins testified that she advised Beverly that she may want to go to an attorney to seek custody of Mya because DSS was unable to give Beverly custody of Mya since the child had been returned to the custody of Turnage.

On June 3, 2003, White came to Jenkins' office to be interviewed in connection with the May incident. During this interview, White indicated that on May 22, 2003, he was caring for Rheanna and Mrs. White was caring for Mya. He explained that when Mrs. White fell sick and had to be taken to the hospital, he had to pick up Mya from Mrs. White's home and bring both of the children to Smith's home.[23]

Smith testified that on her second visit to Turnage's home, the Whites were present. Turnage explained to Smith that Mrs. White was caring for the children and again refused to allow Smith to care for the children. Jenkins denied receiving a referral from, or speaking to, Smith around June 19. According to Turnage's brother, George, and Mrs. White, Turnage never resided with White, but there was a two-week period in May or June during which White stayed with Turnage to help with Rheanna, who was very sick. Mrs. White explained that she had taken vacation time from her job and was there also.

On June 27, 2003, DSS's case staff concluded that White should not be used as a caretaker for either child. DSS's file record of the April and May incidents was closed on June 30. Jenkins visited Turnage's home on July 18, 2003, to discuss the final findings of the case. According to Jenkins, she found the children to be happy. Although the investigation of the April incident was inconclusive for physical abuse, it was valid for lack of supervision; therefore, Turnage was advised

[23] White blamed Smith for the abused and neglected appearance and condition of the children.

that White was not to have any unsupervised contact with the children and that he was not to serve as their primary caregiver. According to Jenkins, Turnage indicated that she could rely on Smith to help with childcare. Nonetheless, Jenkins' case notes reflect that Turnage was very upset and stated that she did not know how DSS expected her to pay her bills and provide a place for her family to live, without which she suspected that DSS would take the children from her.

On September 15, 2003, a concerned citizen, Darla Short (Short), called 911 and reported seeing a driver who kept turning and looking to his right in a real erratic manner. Short indicated that the driver swung two or three times and hit down towards the seat where a child was situated. On his third swing, the car veered all over the lane in which he was traveling. Short stopped following the vehicle when a policeman pulled the driver over. Although she did not then know the identity of the driver, she later saw him (White) on the news. Bettis denied that DSS was ever informed about a 911 call.

On September 23, 2003, White telephoned Turnage, who was at work, to inform her that he could not wake up Mya. Turnage went to White's home to check on Mya. Upon finding her to be unresponsive, Turnage brought Mya to River West Medical Center. Turnage reported that Mya had fallen three or four days before while Turnage was carrying her. Turnage explained that she did not notice the bruises on Mya until that night when she attempted to wake her up. There were bruises on Mya's head, forehead, arms, eyes, ears, back, shoulders, and lower legs. Mya also had a lump on top of her head, hematomas on her forehead, abrasions and scratches on her face and both thighs, and a skin tear on her buttock. Subsequently, Mya was transferred to OLOL.

On September 24, 2003, Dr. Stephen L. Papizan, a pediatric cardiologist, saw Mya in OLOL's pediatric critical care unit. Mya's diagnosis was cardiovascular failure, respiratory failure, massive blunt trauma, closed head

injury, multiple bruising, anal trauma, and cardiac arrhythmias, all suspected to be secondary to nonaccidental trauma in the caretaker's home.

Concerning Mya's injuries, Turnage initially reported to OLOL personnel that Mya had fallen with her down some steps approximately two days prior to her admission to the hospital. Subsequently, Turnage admitted that she had not been truthful because of her fear of losing her children as she had previously been warned by DSS not to leave her children with White. Although she had fallen with Mya a few days previously, Mya only sustained slight bruising from the fall because she had fallen on top of Turnage. Turnage admitted to Dr. Papizan that Mya had been in White's care for the past two days and that White had contacted her on the night of September 23, 2003, when he could not awaken Mya. In light of these remarks, medical personnel suspected that a family member had abused Mya.

Interviews conducted by DSS following the September 2003 incident revealed the following pertinent information. The children had not been cared for by Delane for about three weeks. During that time period, Thomas and Misty O'Quinn, friends of Turnage who had moved from Massachusetts and were looking for a place to live, had been living with Turnage and keeping the children while Turnage worked. Turnage and Mrs. O'Quinn reported that this was the second time Turnage had allowed the children to go with White.[24] According to Turnage, the children would cry when they could not go with White. Turnage refused to believe that White would do anything to harm Mya or Rheanna. According to Ms. O'Quinn, White picked up the children and they stayed with him for three or four days. Ms. O'Quinn reported that both children came home with scratches, which

[24] Turnage could not recall the date of the other time she had allowed the children to go with White.

White explained had occurred as a result of them falling when he pushed them out of the way of the neighbor's Rottweiler.

Turnage and the O'Quinns stated that Turnage had left Mya and Rheanna with White on Monday, September 22, 2003, around noon. Turnage explained that she spoke to Mya and Rheanna that night. White called Turnage at work on September 23, 2003, about 10:00 p.m. and reported that he could not wake Mya. Turnage went to get Mya and brought her to the hospital. Turnage could not remember if she had talked to the children on September 23. She called the O'Quinns to have them pick up Rheanna from White. According to Jenkins, DSS took custody of Rheanna on September 23.

In addressing Jenkins' post-May 22 actions in the instant matter, Cindy Phillips (Phillips), the section administrator of the child protection program for DSS, opined that Jenkins did the right thing under the circumstances. According to Phillips, if a caseworker is ordered by a judge to work with the family, then he or she would do just that. We note however that in this case, the judge had revoked his only order in this matter, and though he had indicated his desire that they work it out, he made it clear that DSS was free to seek a hold order from another judge. Nonetheless, Phillips testified that DSS's objective is to ensure that children are first and foremost protected from abuse and neglect and to reduce the recurrence of child abuse and/or neglect of children while in the custody of DSS. Its role as protector is to respond to reports of child abuse and neglect based on the rules and regulations of the Louisiana Children's Code and DSS policy and procedures. If a DSS worker believes that a child is in clear and substantial danger, his or her first responsibility is to get the child out of the harmful situation.

DSS officials said after June 2, 2003, they did not receive any calls or reports from anyone--family members, friends, police, or doctors--until September 23, 2003. Jenkins denied having received a call about White beating a child in a

car or about Smith's suspicions that White was living in the same house as the children.

Dr. Darlyne Nemeth, a clinical psychologist and clinical neuropsychologist called as a witness by Stewart, testified that the presence of a subdural hematoma combined with seizure activity is a very strong indicator of abuse. Based on the information provided to her, which indicated signs of severe abuse, Dr. Nemeth opined that DSS did not do what should have been done in this case in evaluating the child, parent, and caretaker. Her opinion was based on the fact that Mya was allowed to return to Turnage's care after suffering a subdural hematoma with related seizures, since children of Mya's age do not usually suffer from such a condition in the absence of abuse. Dr. Nemeth stated it was highly unlikely that a hit in the head by a child of Rheanna's age would cause that type of injury.

According to Dr. Nemeth, the medical records indicated a history of abuse, especially considering the subdural hematoma resulting in seizures. Specifically, she referenced the injuries that were sustained by Mya in January 2001, August 2002, April 2003, and May 22, 2003. Dr. Nemeth faulted those involved for failing to see through the excuses that were given.

Dr. Nemeth was critical of the medical treatment rendered to Mya in that she believed that a neurologist rather than an ophthalmologist should have evaluated Mya's subdural hematoma and that a Glasgow Coma Scale test should have been performed when Mya was admitted into the emergency room. Dr. Nemeth conceded that a social worker would have to go by what the doctor said, but opined that DSS had the responsibility of understanding what a subdural hematoma and seizures mean and to act accordingly for the best interest of the child. She further opined that if DSS suspected abuse, but a judge ordered that the child be returned to the parent, DSS "should have gone further."

Liability of DSS

Based on our thorough review of the entire record in this matter, we conclude that there is sufficient factual evidence in the record to support the jury's finding that Jenkins' conduct constituted gross negligence in the handling of this matter. As outlined above, there were several instances in which Jenkins failed to follow DSS policies and procedures in investigating the reports of abuse made to her. Jenkins could have performed a more complete investigation of this matter by contacting a clinical psychologist for the purpose of evaluating Mya and Rheanna,[25] by speaking directly to Mya's treating physician following the April incident, and by making regularly scheduled visits to Turnage's home immediately following Mya's release from the hospital in April 2003.[26]

Startlingly, Jenkins did not establish an immediate safety plan[27] following Mya's discharge from OLOL in April 2003, despite being informed by Turnage that she did not have anyone other than White to help her with the children while she worked. While Jenkins did speak with Smith, who told Jenkins that she was willing to care for Mya and Rheanna, Jenkins did not have Turnage sign a written safety plan documenting her understanding and agreement to allow Smith to

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[25] Jenkins testified that DSS did not always contact a child psychologist when dealing with children of Mya's age or with disabilities. Nonetheless, Dr. Nemeth testified that she had been hired on previous occasions by DSS for cases in East Baton Rouge and Livingston Parishes.

[26] Jenkins also stated that the number of home visits performed is left to the discretion of the caseworker. Section 4-525B of the Office of Community Services Program Policy Manual states that in cases involving a Level 1 investigation, a home visit *must* occur within the time frame for subject contacts and if a home visit is not completed, supervisory approval and documentation of the rationale must be included in the record. Section 4-525A provides that all adult and child subject contacts are expected to be completed as soon as possible, but within 10 calendar days of the receipt of a report by the agency or initiation of the investigation. No such visit or documentation is contained in the record for Mya's case, which was designated a Level 1 investigation.

[27] A safety plan is used to establish immediate supports or interventions to control the immediate harm. Examples include removal of the perpetrator, protective services day care, a voluntary parental arrangement for a child to stay with a relative or friend for a temporary period of time, and court intervention with placement outside of the home. A safety plan is designed to control the circumstances that make the child unsafe and therefore reduces the danger to the child when factors are controllable with implementation of the plan. Office of Community Services Program Policy Manual Section 4-100(D)(41).

provide such childcare and not to allow White to care for the children.

Further, despite testimony by Jenkins and Butler that the district court judge ordered DSS to return the children to Turnage and assertions by DSS that Jenkins was required to obey such an order, it was reasonable for the jury to discredit this testimony since the district court judge expressly denied giving such an order and Jenkins did not document such an order in her case notes.[28] Moreover, the jury reasonably could have found that Jenkins should have gone to another judge to obtain an order to retain custody of the children based on the following:

- The district court judge advised Jenkins that she could get another judge to issue the hold order since the reason he was vacating the order was because his relationship to Turnage restricted him from issuing the order.

- The danger and risk posed to the children that prompted DSS to seek the issuance of the verbal hold order still existed. DSS did not believe nor was it reasonable for it to believe that the children were not at risk if they were returned to Turnage's custody in light of the medical evidence DSS possessed documenting the severity of the injuries the children had sustained in the past while in White's care, and as a result of the mother allowing White to provide childcare and in light of Turnage's history of continuing to allow White to care for the children despite prior admonitions from DSS and agreements from Turnage not to allow White to do so following the 1997 and April 2003 incidents. Additionally, DSS expressed and documented its disagreement with the district court judge's decision to vacate the verbal hold order for those reasons.

- By Jenkins' own testimony, it was not impossible for DSS to have fulfilled the district court judge's acknowledged request for DSS to work with Turnage and still retain custody of the children. As Jenkins testified at trial, "even if we had kept the child in foster care ... our plan would have been to work with the parent, and [if] the parent that we removed from would have did all the necessary things that she had to do, one of our obligations at that point would have still been to return back to that parent."

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[28] According to the contemporaneous notation Jenkins made on her case activity sheet, the following transpired relative to the aborted 72-hour hearing on May 23, 2003:

> Spoke with [Judge] in regards to Melissa Turnage and her minor children. [Judge] advised that he had to [rescind] his VHO granted on 5-22-03 regarding the Turnage Family. He stated Ms. Turnage is related to him and he should not have issued a Verbal Hold Order. VHO [rescinded] [b]y [Judge].
>
> [Judge] stated we could request a hold order from another Judge[;] however [he] requested that we talk with the mother, find out what is going on with her children and work to help her with services.

- And despite DSS's claims that it did not seek to get a hold order from another judge because it would be considered "judge shopping," DSS did seek and obtain a hold order from another judge of the district court to obtain custody of Rheanna in September 2003, acknowledging that it did not seek to obtain the order from the previous judge because the judge had a conflict of interest that prohibited him from issuing the order.

Jenkins admitted several times during her testimony that she was neglectful in the way she handled the investigation of Mya's case, from failing to fully and accurately complete required documentation to failing to interview and monitor Mya, her family, and other witnesses as required by departmental guidelines. Jenkins attempted to excuse some of her neglect with the explanation that it was not the agency's practice to strictly follow certain rules in the agency's policy guidelines. While her testimony about such practices might personally excuse Jenkins' conduct in part, it does not excuse or relieve DSS of responsibility for allowing such a practice to prevail.

Jenkins admitted that following Mya's release from the hospital in April 2003, she did not know who was caring for Mya; yet, she did not perform a home visit, which was required to be performed within ten days of the initial incident report being received by DSS, until May 23, 2003, following the second report of suspected abuse. Likewise, following the May 2003 incident, Jenkins waited nearly a month, until June 20, 2003, to perform another home visit and personally observe how Mya was doing, although Turnage's history of noncompliance would clearly warranted closer monitoring of the family. Hence, the jury was likely unpersuaded by DSS's assertion that despite Turnage having previously ignored DSS instructions regarding White, it had no way of knowing that Turnage would again fail to follow the agency's recommendations. Such confidence in Turnage to do the right thing may have appeared equally implausible to the jury in light of Turnage's statement to Detective Young that she had noticed bruises on Mya on Mother's Day, but had not reported the injuries to the authorities nor questioned

Smith about the injuries out of fear that her children would be taken from her. Such a statement could have reasonably been viewed by the jury as a display of Turnage's tendency to elevate her own concerns above the safety and welfare of her children, which should have been evident to and appropriately addressed by DSS. According to the case report completed by Jenkins relative to the May 2003 incident, Jenkins obtained a copy of Detective Young's investigation report in conjunction with her investigation of that incident.

In line with Jenkins' failure to adequately monitor Mya's care and safety following the April and May 2003 incidents were assertions by Smith that she called Jenkins on more than one occasion and informed her that Turnage was still allowing White to care for the children after the May 2003 incident in contravention of DSS's orders. Jenkins denied receiving any phone calls from Smith, but it was within the province of the jury to credit the testimony of Smith over that of Jenkins.

The jury may have rejected as unreasonable the testimony from Jenkins and other DSS workers attempting to mask the mistakes made by shifting all responsibility for wrongdoing to Turnage. Bettis opined at trial that DSS can only interfere with parental rights if a parent is unable to protect the child, but the jury could have found that there was sufficient evidence presented to DSS that Turnage was unable to protect her children and DSS's failure to recognize and address this fact was substandard conduct on its part. Jenkins further indicated that the duty to protect children rests solely with the parent and DSS's job is simply to help a parent to protect the child, while Martina Gauthreaux, assistant secretary of the Office of Community Services, opined that DSS's primary goal is to keep families unified if at all possible. While such goals may be commendable, if feasible, it is not the primary objective of the agency as expressed in its policy manual and by

law.[29] Further, to the extent that such an objective compromised the proper handling of Mya's case by Jenkins, the goal of maintaining family unity could still have been safely achieved in compliance with agency guidelines if Jenkins had followed mandated procedures to investigate possible placement of Mya with other relatives, such as with Mya's father, Stewart, or her grandmother, Beverly. While Beverly arguably could have been more proactive and assertive in seeking custody of Mya by heeding Jenkins' advice to seek legal counsel to assist in obtaining custody of Mya, such failure by Beverly did not invalidate her offer to have Mya placed with her or excuse Jenkins' failure to investigate such possibility as required by the agency's guidelines.

The "OCS Program Policy Manual" is the guideline to be used by caseworkers in evaluating reports of child abuse and neglect. In the chapter of the manual covering "Child Protection Investigation," the following statement is found in the introduction of the chapter:

> The goal of Child Protection Investigation Services is *to protect children* from abuse, neglect, exploitation or abandonment; and to ensure their safety through protective investigation, social services provision and legal intervention to remove them from that environment when it seriously threatens their safety and well being. [Emphasis added.]

While the guidelines provided to caseworkers do not preclude latitude in the performance of the caseworker's duty, such latitude or exercise of discretion in *complying* with the guidelines cannot be construed as authorization to completely ignore or to not comply with such guidelines. See Todd, 96-3090 at 14, 699 So.2d at 42; see also Oliveaux v. St. Francis Medical Center, 39,147 (La. App.

[29] Subpart C of Section 4-100 of the OCS Program Policy Manual lists eight objectives for Child Protection Investigation Services, with the goal "to maintain family unity and prevent removal of the child" appearing last on the list. See also La. Ch.C. art. 601("The health, safety, and best interest of the child shall be the paramount concern in all proceedings under [Title VI of the Louisiana Children's Code].")

2d Cir. 12/15/04), 889 So. 2d 1264, 1272, writ denied, 05-0454 (La. 4/29/05), 901 So. 2d 1067.

Based on the totality of the errors committed by Jenkins in investigating, monitoring, and handling Mya's case, we find there was sufficient evidence presented to support the jury's finding that Jenkins' investigation in this case was so incomplete as to be grossly negligent. Whereas the errors and mistakes committed by Jenkins separately would have been insufficient to support a finding of gross negligence, the repeated failures to follow departmental guidelines and to diligently seek the best interests of the child, as opposed to the interests of the mother or her own professional interests as a caseworker, in the given time frame (six months), combined to establish the requisite degree of negligence to impose liability on DSS. Hence, we find no error in the assessment of liability against DSS.

Allocation of Fault

When fault is attributable to more than one tortfeasor, La. C.C. art. 2323(A) provides, in pertinent part:

> In any action for damages where a person suffers injury, death, or loss, the degree or percentage of fault of all persons causing or contributing to the injury, death, or loss shall be determined, regardless of whether the person is a party to the action or a nonparty, and regardless of the person's insolvency, ability to pay, immunity by statute, including but not limited to the provisions of R.S. 23:1032, or that the other person's identity is not known or reasonably ascertainable.

The allocation of fault between comparatively negligent parties is a finding of fact. As with other factual determinations, the trier of fact is vested with much discretion in its allocation of fault. Accordingly, an appellate court may only reallocate fault if it finds the trial court was clearly wrong or manifestly erroneous in its allocation of fault. Gregor v. Argenot Great Central Insurance Company, 02-1138, p. 14 (La. 5/20/03), 851 So. 2d 959, 968.

In Watson v. State Farm Fire and Casualty Insurance Company, 469 So. 2d 967, 974 (La. 1985), the Louisiana Supreme Court identified various factors that may influence the degree of fault assigned, including: (1) whether the conduct resulted from inadvertence or involved awareness of the danger; (2) how great a risk was created by the conduct; (3) the significance of what was sought by the conduct; (4) the capacities of the actors, whether superior or inferior; and (5) any extenuating circumstances that might require the actor to proceed in haste, without proper thought.

Considering these factors, we find that the jury was clearly wrong in its allocation of fault. Although we find that the record supports the jury's assessment that DSS's conduct, through its employee, was grossly negligent and fell well below the standard of care expected, we do not consider such gross negligence to be the primary cause of the harm suffered by Mya. Clearly, the greater danger and risk was posed by White's conduct, which was the direct cause of the harm suffered by Mya, as opposed to the conduct of Jenkins, which was an indirect cause based on Jenkins' incomplete investigation, monitoring and handling of Mya's case that resulted in Jenkins' failure to realize and appreciate the danger posed to Mya by her caregivers. Further, as there was no assurance of Mya's safety even if there had been thorough and complete investigation, monitoring, and handling of Mya's case, White clearly had the superior capacity to guard against the harm inflicted.

After the court of appeal finds a "clearly wrong" apportionment of fault, it should adjust the award, but only to the extent of lowering or raising it to the highest or lowest point respectively that is reasonably within the jury's discretion. Clement v. Frey, 95-1119, pp. 7-8 (La. 1/16/96), 666 So. 2d 607, 611. Accordingly, we find that under the circumstances presented in this matter, the highest degree of fault that reasonably could be attributed to the DSS would be 25 percent. And as Turnage was made aware of the danger posed by White and was

repeatedly instructed not to allow White to care for the young child, we likewise re-allocate the jury's determination of fault to attribute 25 percent fault to Turnage, who failed to follow DSS's instructions or take any measures to protect her child. The remaining degree of fault, 50 percent, we attribute to White, the perpetrator of the heinous and severely grave harm suffered by the young victim.

Survival Action Damages

Louisiana Civil Code article 2315 authorizes a tort victim to be compensated for damage sustained as a result of the delict. McGee v. A C and S, Inc., 05-1036, p. 4 (La. 7/10/06), 933 So. 2d 770, 774. The term "damages" refers to pecuniary compensation, recompense, or satisfaction for an injury sustained. McGee, 05-1036 at 3, 933 So. 2d at 773. While it is impossible to place a monetary value on the life of a child, our jurisprudential system has established that a monetary award is the appropriate remedy for one who has suffered the loss of a loved one as a result of the fault of another. Rideau v. State Farm Mutual Automobile Insurance Company, 06-0894, p. 17 (La. App. 1st Cir. 8/29/07), 970 So. 2d 564, 580, writ denied, 07-2228 (La. 1/11/08), 972 So. 2d 1168.

The survival action is a right granted to designated beneficiaries to recover all damages for fatal injury to the deceased, his property or otherwise, caused by the offense or quasi offense from which the fatal injury arose. La. C.C. art. 2315.1. A survival action comes into existence simultaneously with the tort and permits recovery only for the damages suffered by the victim from the time of injury to the moment of death, and is transmitted to the victim's beneficiaries upon his death. Louviere v. State, Louisiana Department of Education, 04-1897, p. 5 (La. App. 1st Cir. 9/23/05), 923 So. 2d 146, 149, writ denied, 05-2258 (La. 4/24/06), 926 So. 2d 538.

A trial court is within its much discretion in awarding survival damages for pain and suffering where there is the smallest amount of evidence of pain on the

part of the deceased by his actions or otherwise. Barthel v. State, Dept. of Transportation and Development, 04-1619, p. 9 (La. App. 1st Cir. 6/10/05), 917 So. 2d 15, 21. It is only when the award is, in either direction, beyond that which a reasonable trier of fact could assess for the effects of the particular injury to the particular plaintiff under the particular circumstances that the appellate court should increase or reduce the award. Youn v. Maritime Overseas Corporation, 623 So. 2d 1257, 1261 (La. 1993), cert. denied, 510 U.S. 1114, 114 S.Ct. 1059, 127 L.Ed.2d 379 (1994). Only after it is determined that there has been an abuse of discretion is a resort to prior awards appropriate, and then only to determine the highest or lowest point of an award within that discretion. Rideau, 06-0894 at 17, 970 So. 2d at 579.

The exact time that Mya sustained the injuries that eventually caused her death is unknown; however, the record reveals that around noon on September 22, 2003, Turnage left Mya in White's care. About 10:00 p.m. the next evening, White called Turnage at work and told her that he could not awaken Mya. Turnage went to White's home, found Mya to be unresponsive, and took her to the River West Medical Center. On being examined at the River West Medical Center, the following was documented as the injuries sustained by Mya:

> She had bruises on her head, forehead, top of head, right and left arms, right and left eyes, right and left ears, back (3-5 cm in diameter), shoulders, lower legs, lump on top of head, hematomas (knots from injury) on her forehead, right and left thigh abrasions and scratches, abrasions and scratches to the face, skin tear on the buttock.

A CT scan of Mya's brain showed "loss of gray white matter compatible with massive cerebral edema (brain swelling) in both hemispheres resulting in prominent mass effect and a midline shift to the right with herniation and hemorrhage." There was also swelling of the scalp. Mya was transferred to the Pediatric Intensive Care Unit of OLOL on September 24, 2003, where she was seen by Dr. Papizan.

At trial, Dr. Papizan described Mya's injuries as follows:

> First of all, she was unresponsive. She wouldn't respond to pain or voice or any stimulus. She had livid bruising on the face and shoulders, as well as around the eyes, forehead. And all those bruises – there was swelling around those bruises. ... she was breathing very rapidly in the ER. By the time she was ...to the ICU, she was on a breathing machine. She had a high temperature. She had a very high blood pressure. She had bruises on both sides of the forehead, extending down to the eyelids, and on the right side of the temple. There was bruising behind the ears and down below the ears. ... Her eyes were red. She didn't move her eyes at all. She had a large purple bruise on her chest, collar bone and shoulder area. There were many bruises on the upper arms, and a fairly big bruise on the left arm. Her heart rate was irregular and very rapid....Her stomach was swollen and extended. There was a tube into her stomach. I didn't hear normal stomach movement.

Given the nature of the various locations of the bruises on Mya, Dr. Papizan said that it definitely took more than one blow to cause the injuries sustained by Mya and acknowledged that as a result, Mya went through a traumatic experience before she died.

The elements of damage for the survival action are pain and suffering, loss of earnings and other damages sustained by the victim up to the moment of death. In re Brewer, 05-0666, p. 5 (La. App. 1st Cir. 5/5/06), 934 So. 2d 823, 826, writ denied, sub nom In re Medical Review Panel for Claim of Brewer, 06-1290 (La. 9/15/06), 936 So. 2d 1278. Loss of enjoyment of life[30] is also an element of damage in a survival action for which recovery can be awarded, if the damages from such loss are sufficiently proven. McGee, 05-1036 at 7, 14, 933 So. 2d at 776, 780. The factors to be considered in assessing quantum for pain and suffering in a survival action are the severity and duration of the pain. Hampton v. Rubicon Chemicals, Inc., 579 So. 2d 458, 469 (La. App. 1st Cir. 1991).

We find that the amount of damages awarded was an abuse of the jury's discretion, since the only element of the survival action applicable to her claim

[30] Loss of enjoyment of life refers to the detrimental alterations of a person's life or lifestyle or a person's inability to participate in the activities or pleasures of life that were formerly enjoyed. McGee, 05-1036 at 3, 933 So. 2d at 773.

would be for pain and suffering. The injuries sustained by Mya unquestionably were traumatic and extremely grave. By the time Mya had arrived at OLOL, it was recorded that she was not responding to any stimuli, including pain, and certainly the nightmarish way in which her short life ended was tragic. Accordingly, considering the evidence presented and other survival action damages awards for the death of a young child, we find that the highest award within the jury's discretion would have been $2,000,000. See Conerly v. State, 97-0871 (La. 7/8/98), 714 So. 2d 709 ($2.5 million awarded in a survival action of a child that died the day before her fifth birthday as a result of injuries suffered as a result of medical malpractice committed by the doctor during her birth). Cf. Launders v. Steinberg, 39 A.D.3d 57, 828 N.Y.S.2d 36 (2007).

CONCLUSION

For the foregoing reasons, the judgment of the trial court is amended to re-allocate the percentages of fault to assign 50 percent fault to Jessie White, 25 percent fault to Melissa Turnage, and 25 percent fault to DSS. We further amend the award to reduce the award of survival damages to $2,000,000. In all other respects, the judgment of trial court is affirmed. Costs of this appeal in the amount of $6,925 are assessed to the State of Louisiana through the Department of Social Services.

AMENDED, AND AS AMENDED, AFFIRMED.

NOT DESIGNATED FOR PUBLICATION

STATE OF LOUISIANA

COURT OF APPEAL

FIRST CIRCUIT

2006 CA 0607

TRAVIS STEWART, INDIVIDUALLY AND ON BEHALF OF HIS DECEASED MINOR CHILD, MYA GEORGE

VERSUS

STATE OF LOUISIANA THROUGH DEPARTMENT OF SOCIAL SERVICES

BEFORE: CARTER, C.J., WHIPPLE, PARRO, KUHN, GUIDRY, PETTIGREW, DOWNING, GAIDRY, McDONALD, McCLENDON, HUGHES, AND WELCH JJ.

PARRO, J., dissenting.

Based on my review of the entire record, I disagree with the majority's conclusion that there is sufficient factual evidence in the record to support the jury's finding that Ruby Jenkins' conduct constituted gross negligence in the handling of this matter. My belief is based on the consideration of the facts set out in the majority opinion and the following evidence that was offered at trial.

During the course of her employment, Ruby Jenkins (Jenkins) had investigated the household of Melissa Turnage (Turnage) in connection with a fracture to Rheanna Turnage's (Rheanna's) leg in September 1997 that had occurred while she was in the care of Turnage's stepfather, Jessie White (White). In connection with that investigation, Turnage stated that White would not have intentionally hurt Rheanna. Turnage indicated that White had provided care for Rheanna ever since she came home from the hospital. According to Turnage, White loved Rheanna and was very upset about her injury. Although Rheanna's pediatrician could not say that the injury was a

result of abuse, the case was validated by DSS for neglect. Pursuant to its conclusions, DSS advised Turnage that White was not to render unsupervised care to Rheanna.

Three years later, in September 2000, Mya George (Mya) was born. Turnage's brother, Joseph George, testified that Turnage and her children lived with him following Mya's birth. After leaving George's home, Turnage went to live with Johnanna Johnson and Anthony Bailey for a period of about five months.

As early as January 3, 2001, Mya's pediatrician, Dr. Katherine Elkins, observed a bruise between Mya's eyes on her forehead. This bruise reportedly resulted from a hit by Rheanna. Dr. Elkins testified that she was not suspicious of Turnage's account of the incident. Turnage noted that Rheanna was prone to doing that type of thing. Dr. Elkins testified that she would have contacted protective services had she suspected abuse at that time. On August 1, 2002, Dr. Elkins' partner, Dr. Michael Quinn, saw Mya in connection with bruises on the side of her face, the ear, and behind the ear, which had reportedly occurred when Mya fell down the bleachers at a baseball park while with her aunt. Dr. Quinn also noted that Mya was walking with a limp. Dr. Elkins testified that the related medical records gave no indication that anyone suspected abuse at that time. Again, DSS was not contacted in connection with that incident.

Jenkins denied receiving any reports about possible abuse of Rheanna or Mya in 1998, 1999, 2000, 2001, or 2002. It was not until after the April 11, 2003 incident that DSS was contacted by a hospital social worker, Maria Cashio, about the possibility of Mya being abused. About her subsequent investigation, Jenkins testified that although the Office of Community Services' policy requires that a caseworker speak with a doctor during the course of an investigation, it is not always possible to speak to a doctor. During her visit to the hospital on April 15, 2003, none of Mya's treating physicians were available to speak with her.

When questioned about the decision to consult with DSS concerning Mya's April 2003 condition, Dr. Elkins noted that child protection services are consulted any time there is a significant injury such as a subdural hematoma. Nonetheless, Dr. Elkins did not at that time have a concern about child abuse. Furthermore, the consulting

ophthalmologist's report indicated that there was no sign of abuse or neglect of the child as there was no conclusive evidence that the injury was purposefully done. Dr. Elkins had no reason to question the ophthalmologist's opinion that there were no signs of child abuse. Dr. Elkins testified that in light of the two doctors' opinions,[1] it was logical for Jenkins not to suspect abuse.

Although plaintiff's expert, Dr. Darlyne Nemeth, opined that DSS had the responsibility of understanding what a subdural hematoma and seizures mean and to act accordingly for the best interest of the child, she ultimately conceded that a social worker would have to go by what the doctor said and reasoned that if the pediatrician did not suspect abuse, it is understandable why DSS did not act.

Jenkins explained that although it may have seemed that it was impossible for Turnage to work without having White care for her children, DSS is not always in a position to automatically take action based on what it suspects a parent may do or may not do. Furthermore, at that point, Jenkins had determined that Melissa Smith (Smith) was available to help with Turnage's needs for childcare.

Jenkins testified that, considering the information available to her, she investigated this matter to the best of her knowledge and ability. Based on her investigation, Jenkins concluded that she did not have enough evidence to support the issuance of a hold order.[2] Although Jenkins and others feared that White did not provide adequate care and supervision for the children, they did not believe that White would intentionally harm them. The medical providers who knew White said nothing negative in regard to his care of the children. Turnage never reported that she suspected abuse by White. Furthermore, White was very remorseful and concerned as

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[1] Mrs. White, Turnage's mother, testified that following the April 2003 incident, they had brought the xylophone to the hospital for the doctor to see and the doctor stated that the account of events was consistent with the injuries.

[2] The removal of a child from his or her own home is viewed as the alternative of last resort for protection from abuse/neglect, not the first choice. Children removed from their own homes should be those children whose lives are in clear, immediate, and substantial danger if they remained at home and the risk factors do not appear to be controllable with the implementation of a safety plan that includes the children remaining in the home. Office of Community Services Program Policy Manual Section 4-805(A).

to what had happened. At that time, no one, including medical personnel,[3] suspected that it was anything other than an accident. Although the April incident was subsequently validated as to White for lack of supervision, it could not be validated for physical abuse as there was no conclusive evidence of abuse.

Smith reported to Detective Kenneth Young and Officer Leo Fontenot on May 22, 2003, that she had noticed bruises on Mya over the last five months. However, when Smith spoke with Jenkins that same day, Smith did not mention that she had noticed bruises on the children prior to May 22 or that she had been trying to get in touch with Jenkins concerning Mya's wellbeing.[4]

Based on the facts known to her at that time, Jenkins believed there were sufficient grounds to justify the issuance of a verbal hold order, authorizing her to take Mya and Rheanna into state custody. The district court judge, who usually handled DSS's matter of this nature, agreed. Once the hold order was rescinded based on its alleged improper issuance, the issuing judge told Jenkins that another judge could be contacted to obtain a hold order. Nonetheless, the judge requested that Jenkins and her co-worker, Chris Butler (Butler), speak to and work with Turnage.[5] The issuing judge admittedly questioned Jenkins and Butler about the availability of services to assist Turnage with childcare. According to the issuing judge, Jenkins and Turnage then went into his library to discuss the matter. Considering the circumstances and the

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[3] On May 22, 2003, Mya was treated for bruising at Dr. Elkins' office. In addition to the bruises, Mya had a right ear infection with a hole in her eardrum. The diagnosis was a non-accidental trauma. Dr. Elkins believed for the first time that Mya was a victim of child abuse. However, in retrospect, Dr. Elkins questioned her April 11 notation that indicated a lack of concern about child abuse and realized that the subdural hematoma could have been caused by something other than a plastic hammer.

[4] Although Smith testified that she attempted to report suspected child abuse on several occasions, there was no evidence to substantiate her claims. She could not give any specific information about her efforts. She did not know what telephone number she had called or to whom she had spoken. Furthermore, except for May 22, 2003, she never telephoned the local police or filed a report concerning her alleged suspicions.

[5] According to Jenkins, after acknowledging a familial relationship to Turnage, the issuing judge indicated that Turnage was a good girl and that he did not believe that she was doing anything to the children.

judge's request,[6] Jenkins felt that DSS had put together the best plan possible to reduce the risk to the children, which included the children being cared for in their home by one of Turnage's friends, Kimberly Delane. Once again, Turnage was provided with information on all of the available community resources, was offered counseling on appropriate parenting, and was instructed to advise the agency of any changes in these childcare arrangements. In light of the events that had recently transpired, Jenkins explained that DSS was not in a position on June 2, 2003, to take Mya from Turnage to give her to Gertrude Beverly (Beverly). Nonetheless, Jenkins advised Beverly to obtain counsel and have legal proceedings instituted to obtain custody of Mya. Beverly failed to take Jenkins' advice.

Robin Bettis, a child welfare district manager with DSS, testified that she had regular case conferences with Jenkins about Mya and Rheanna. She felt that the safety plan[7] prepared in May was adequate. According to Bettis, DSS cannot guarantee that a plan will work. Bettis explained that in preparing a plan, DSS workers do their best in addressing the issues of safety and risk to children. In the instant case, the safety plan ordered that Turnage not allow White around Mya and Rheanna.[8] The judge advised Turnage to cooperate with DSS and to adhere to any recommendations made to her. The safety plan contemplated that Delane would care for the children. The fact that Turnage had previously ignored DSS's instruction that the children not be left in White's care did not automatically put DSS on notice that this safety plan was unworkable.

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[6] Robin Bettis, a child welfare district manager with DSS, testified that she and Jenkins discussed the fact that they are required to abide by a court order and they cannot go from judge to judge to get a ruling that would be favorable to DSS. Butler stated that the judge wanted DSS to give Turnage another chance.

[7] A safety plan is used to establish immediate supports or interventions to control the immediate harm. Examples include removal of the perpetrator, protective services day care, a voluntary parental arrangement for a child to stay with a relative or friend for a temporary period of time, and court intervention with placement outside of the home. A safety plan is designed to control the circumstances that make the child unsafe and therefore reduces the danger to the child when factors are controllable with implementation of the plan. Office of Community Services Program Policy Manual Section 4-100(D)(41).

[8] According to Detective Young, Smith's suspicions of abuse by White were insufficient to support an arrest of White in connection with Mya's May 22 injuries. Smith did not know anything for certain and had not seen White being abusive to the children.

In addressing Jenkins' post-May 22 actions in the instant matter, Cindy Phillips (Phillips), the section administrator of the child protection program for DSS, opined that Jenkins did the right thing under the circumstances. According to Phillips, if a judge requests that a caseworker work with the family, then the caseworker would do just that. Thus, Jenkins was left believing that she had to comply with the judge's recommendation. Under these circumstances and in the absence of proof that Turnage was not complying with the safety plan, DSS was without authority to remove Mya from Turnage's home and place her in Beverly's home in connection with Beverly's June 2, 2003 request.

Based on my thorough review of the entire record in this matter, I do not believe that the facts provide a reasonable basis for the jury's finding that Jenkins' conduct constituted gross negligence in the handling of this matter. Furthermore, I think such a finding is clearly wrong. Granted, Jenkins' conduct in investigating these reports of abuse was not ideal, in that DSS's policies and procedures were not always followed by Jenkins to the letter. Notably, DSS's policy manual is a guideline to be used by a caseworker in evaluating a situation. Thus, a finding that Jenkins' failure to strictly adhere to the guidelines established in DSS's policies and regulations constituted gross negligence is not supported by the record and is clearly wrong. Clearly, the guidelines provided to caseworkers do not preclude any latitude for action in the performance of the caseworker's duty. See Todd v. State, through Department of Social Services, Office of Community Services, 96-3090 (La. 9/9/97), 699 So.2d 35, 42. When considering the latitude afforded to caseworkers in investigating matters of this nature,[9] a finding that Jenkins' investigation in this case was so incomplete that it could not be found to be thorough is manifestly erroneous. Accordingly, I feel that the jury's finding of gross negligence under the facts of this case is contrary to the spirit of the law and the decision in Todd.

[9] According to Jenkins, the number of home visits is discretionary with the caseworker, and DSS did not always contact a child psychologist when dealing with children of this age or disability.

The entirety of the record supports a conclusion that Jenkins' investigations were conducted within her discretionary authority and were not unreasonable. DSS did not have custody of Mya when the abuses occurred. Neither Turnage's negligence nor White's intentional conduct can be imputed to Jenkins or DSS under the facts of this case.[10] Furthermore, to find Jenkins grossly negligent for failing to find actual abuse to Mya while in the care of White in April 2003 and for failing to defy the judge's request that Jenkins and DSS work with Turnage following the incident of abuse that occurred in May 2003 is purely hindsight and untenable in the law. See Todd, 699 So.2d at 41. Therefore, I believe that the jury manifestly erred in finding that Jenkins' conduct constituted gross negligence in connection with Mya's death. In the absence of a finding of gross negligence, Jenkins and DSS are entitled to the qualified immunity set forth in LSA-Ch.C. arts. 611 and 612 and LSA-R.S. 9:2798.1. Accordingly, liability should not be imposed on DSS, notwithstanding any ordinary negligence that may have occurred in this matter.

For these reasons, I respectfully dissent.

[10] See White v. White, 479 So.2d 588, 589 (La. App. 1st Cir. 1985).

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	COURT OF APPEAL
VERSUS	**STATE OF LOUISIANA**
STATE OF LOUISIANA THROUGH DEPARTMENT OF SOCIAL SERVICES	**NO. 2006 CA 0607**

J.E.K. by JMM

KUHN, J., dissenting.

Given the evidence offered regarding the lack of a relationship of the plaintiff with Mya, the quantum granted by the majority is unreasonably high and shocks the conscience. Likewise, the fault assessed to the State is erroneously high, when the State's conduct is compared to the conduct of Jessie White and Melissa Turnage.

Moreover, I join in the dissent offered by Judge R. Parro.

STATE OF LOUISIANA

COURT OF APPEAL

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2006 CA 0607

TRAVIS STEWART, INDIVIDUALLY AND ON BEHALF OF HIS DECEASED MINOR CHILD, MYA GEORGE

VERSUS

STATE OF LOUISIANA THROUGH DEPARTMENT OF SOCIAL SERVICES

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McCLENDON, J., concurs in part and dissents in part.

As an appellate court we cannot set aside the trial court's factual findings unless we determine that there is no reasonable factual basis for the findings and the findings are clearly wrong (manifestly erroneous). **Stobart v. State, Dep't of Transp. and Dev.**, 617 So.2d 880, 882 (La. 1993). If the findings are reasonable in light of the record reviewed in its entirety, an appellate court may not reverse even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently. **Rosell v. ESCO**, 549 So.2d 840, 844 (La. 1989). Under such circumstances, an appellate court cannot substitute its judgment for that of the trier of fact. **Etcher v. Neumann**, 00-2282, p. 9 (La.App. 1 Cir. 12/28/01), 806 So.2d 826, 835, writ denied, 02-0905 (La. 5/31/02), 817 So.2d 105.

In this matter, I cannot say that the jury was manifestly erroneous in finding gross negligence. When DSS requested that a verbal hold order issue by a district court judge to remove Mya and Rheanna from their mother's custody, DSS obviously believed that there was sufficient evidence to support taking the children into state custody for their safety. The facts did not change simply because the judge recused himself and rescinded his order, based on the fact that he was related

to the mother. Although specifically told by the judge that she could request an order from another judge, Jenkins did not pursue another hold order. Accordingly, I concur with the majority's decision that there was sufficient factual support in the record to support the jury's finding of gross negligence in the handling of this matter.

However, I disagree with the majority's amended award of damages, as well as its re-allocation of fault. Based on the specific facts and circumstances of this case, I believe the maximum amount that could have been awarded for survival damages to Mya's father is $1,000,000. Additionally, I disagree with the majority's allocation of fault believing that ten percent (10%) is the maximum percentage of fault that can be attributed to DSS. Further, I would have attributed sixty percent (60%) fault to Jessie White, the person directly responsible for the death of Mya, and thirty percent (30%) fault to Melissa Turnage, the mother, who despite repeated requests by DSS not to leave her children in the care of White, continued to do so, which resulted in Mya's death.

Therefore, I respectfully concur in part and dissent in part from the majority opinion.