IN THE CIRCUIT COURT OF THE FIFTH JUDICIAL CIRCUIT OF FLORIDA IN AND FOR MARION COUNTY

REPORT OF THE GRAND JURY OF MARION COUNTY, FLORIDA

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FILED

August 27, 2026

Grand Jury Presentment regarding the Florida Department of Children and Families, Circuit 5

INTRODUCTION

The grand jury originated more than seven centuries ago in England. The early colonists brought the grand jury system to this country. It has been with us ever since. It is recognized in the Constitution of the United States and in the Florida Constitution[1]. We, the grand jurors of Marion County, have familiarized ourselves with the Florida Supreme Court's grand jury handbook, and the law as it relates to the authority of the Grand Jury. More specifically our authority "*permits investigation of how public officials are conducting their offices and discharging their public trusts. The grand jury may investigate as to whether public institutions are being properly administered and conducted.*"

This Grand Jury is issuing this report not as a routine administrative review, but to sound an alarm. The Department of Children and Families (DCF) is statutorily mandated to protect our community's most vulnerable citizens: our children and our elderly. DCF in Circuit 5 is failing catastrophically in that duty.

The gravity of this crisis cannot be overstated: on the very day this Grand Jury was empaneled, we indicted a defendant for the first-degree felony murder of a child. We found that DCF investigated and visited this family 14 times prior to the murder. This tragedy is a direct symptom of an agency in crisis. We call upon leadership to review these findings in earnest and work collaboratively to implement the vital structural reforms needed in DCF Circuit 5.

GRAND JURY FINDINGS OF FACT

I. Mission and Statutory Authority

DCF's stated mission is "to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency."

Its authority and duties derive primarily from two chapters in Florida Statutes:

- **Chapter 39:** Child Services
- **Chapter 415:** Adult Protective Services

During this investigation, we learned credible, firsthand information from law enforcement officers, firefighters, lawyers, a member of the judiciary, and employees of a service provider for the Department of Children and Families. We find this information revealed heartbreaking,

[1] Florida Grand Jury Handbook

systemic patterns of neglect and abuse, abrogation of statutory responsibilities, as well as operational failures within DCF- Circuit 5.

II. Organizational Structure

Headquartered in Florida and led by a Secretary, DCF is divided into six regional offices serving 20 judicial circuits.

- DCF Circuit 5 operates within the **Central Region**.
- While headquartered in **Marion County** (where this Grand Jury is seated), its jurisdiction spans all five counties of the Fifth Judicial Circuit: **Marion, Citrus, Lake, Sumter, and Hernando**.
- This investigation reviewed cases, policies, and practices of DCF- Circuit 5.

III. The Abuse Hotline and Intake Process

Reports of child abuse or elder exploitation are routed through a single, statewide **Abuse Hotline (1-800-962-2873)** operating 24/7. Florida law mandates that citizens and professionals report any suspected abuse or caregiver neglect. If a call passes DCF's initial screening, law enforcement or protective services are dispatched. If a call does not make it past the hotline, it is screened out. (Note: Hotline handling concerns are detailed later in this report).

IV. Systemic Failures in Elder Abuse & Exploitation Services

The five-county Fifth Judicial Circuit houses a disproportionately large retiree population, naturally resulting in a higher volume of elder service calls. Regardless of volume, we find that DCF routinely fails to respond to calls, closes cases prematurely without thorough review, and misinterprets policies to shirk its responsibilities.

1. Shifted Burdens and After-Hours Neglect

Adult protective investigators routinely fail to respond to calls after 5:00 PM or on weekends.

- We find that when first responders are reporting after-hours abuse or neglect, the hotline routinely instructs them to transport the individual to an emergency room or a Baker Act[2] facility.
- This occurs even when the individual has no acute medical emergency or mental illness but is suffering from cognitive decline (e.g., dementia or Alzheimer's).
- This practice shifts DCF's placement burdens onto local hospitals. Because DCF fails to provide follow-up casework or safety plans, some individuals remain stuck in

[2] A statutory process whereby an individual is involuntarily committed to a mental health facility because of a determination that they are a harm to themselves or others.

hospital beds for extended periods of time. We learned about one example of an individual waiting up to a year in the hospital for placement.

2. The "Co-Responder" Safety Net

In Marion County, DCF's operational gaps are so severe that local law enforcement, medical professionals, and first responders established an independent **"Co-Responder Program."**

- This multi-agency group meets weekly to review cases and engineer safety plans for vulnerable adults left unprotected by DCF.
- While DCF attends these meetings, local emergency services (the fire department and sheriff's office) are effectively burning their own resources to act as a de facto placement and transport service. Without this program, these vulnerable citizens would have no oversight or safety net.

3. Inadequate Capacity Evaluations

We found that DCF investigators often treat mental capacity evaluations as a box-checking exercise. Investigators have been observed coaching patients to ensure a finding of capacity even when it is apparent there are real capacity issues. A finding of capacity legally relieves DCF of further obligation, routinely abandoning vulnerable individuals in the exact abusive or neglectful environments that triggered the initial call.

4. Broken Promises and Policy Weaponization

This crisis is not new. Over multiple years, on more than one occasion, multiple local agencies have confronted DCF's regional and executive leadership with this evidence. Meetings were held. Assurances were given. Promises were repeatedly made—and routinely broken.

V. Individual Case Reviews

We learned about seven separate cases involving the neglect and abuse of the most vulnerable people in our society: our children and our elderly. The first case, as mentioned in the introduction, was a case that was separately presented in this grand jury and investigated during this proceeding. Below is a summary of six additional cases where systemic inaction allowed severe trauma and preventable fatalities to occur among vulnerable adults and children:

1. **Vulnerable Adult Investigation, case #1:** From late 2023 until late 2024, a vulnerable adult was suffering from advanced Alzheimer's and dementia and was the victim of severe neglect by her sole caretaker. Her caretaker was a known drug user who exhibited frequent manic episodes and drug-induced behavior. The residence was consistently filthy. The vulnerable adult was regularly discovered on the floor, naked or partially clothed, and covered in human waste. At times, the caretaker withheld her prescribed

medications. There were two prior DCF reports and DCF responded to investigate each time. After the first report, the case was closed with a safety plan requiring the caretaker to agree to not use unlawful substances in the home or on the property, despite the fact the caretaker had recently been hospitalized for a drug overdose. This stipulation was handwritten on the court order and was a striking admission that the caregiver was using illegal controlled substances, DCF was aware, and apparently unconcerned. The second report was closed without substantiated findings of medical neglect, inadequate supervision, and environmental hazards. It should be noted, we find that DCF allowed an incapable caregiver to decline placement on behalf of the vulnerable adult on more than one occasion. Six days later, an almost identical allegation was reported which ultimately resulted in the vulnerable adult's death. Despite extensive contact and documented evidence of the caretaker's severe substance abuse and inability to care for the vulnerable adult, DCF failed to intervene.

2. **Vulnerable Adult Investigation, case #2:** DCF responded to two separate reports of neglect in late 2018 and late 2019, where a vulnerable adult was discovered living in severe neglect, covered in insects, feces, and urine. The sole caregiver suffered from COPD and cognitive limitations. We find DCF was aware that the caregiver was incapable of meeting the vulnerable adult's care needs. Simultaneously, the vulnerable adult refused essential hygiene assistance from the caregiver. Rather than initiating protective custody or state guardianship, DCF warned the caregiver of potential criminal neglect charges. DCF then shifted all case management responsibility to the hospital and rehabilitation systems. Following both incidents, medical facilities discharged the vulnerable adult back into the same caregiver's care. DCF conducted zero follow-up investigations to inspect the residence or reassess the caregiver's ability to act as a caregiver. In the summer of 2020, DCF responded to a third call under identical conditions of extreme neglect. The vulnerable adult subsequently succumbed to injuries and illnesses directly caused by her living conditions. DCF possessed actual knowledge over an eighteen-month period that the vulnerable adult was trapped in a lethal environment with an unfit caregiver. Instead of stepping in to save the vulnerable adult, DCF once again failed to protect her or remove her from the hazardous environment. The vulnerable adult's caregiver was subsequently charged with manslaughter.
3. **Child Abuse and Neglect Investigation, case #1:** In late 2022, an infant was born testing positive for amphetamines and methadone. During the mother's pregnancy, she had overdosed and was Baker Acted. Following this child's birth, he was placed into temporary custody of a relative, where he remained in a safe, stable, and loving environment. Approximately one year later, DCF initiated reunification proceedings. Despite repeated warnings from both the caretaker and a case management employee regarding concerns of the parents' ongoing drug use and criminal histories, DCF reunited the child with his father in early 2024. This placement was contingent on the mother not returning to the family home. In direct violation of these terms, the mother resided at the

home for days prior to the child's death. This child suffered a fatal overdose from the combined effects of fentanyl, methamphetamine, and xylazine. This child's death was preventable: had DCF acknowledged the credible warnings of his caregiver and the case management employee, the child would never have been returned to this lethal environment. Both parents were charged with aggravated manslaughter of a child.

4. **Child Abuse and Neglect Investigation, case #2:** In late 2021, an infant was born to a mother with an extensive DCF history. Overall, this mother had five children. Between 2006 and 2023, the mother was the subject of approximately 18 DCF investigations detailing a severe history of substance abuse, involuntary psychiatric commitments, physical abuse, and explicit threats to kill her children. These investigations consistently documented mental instability and cognitive deficits. Following the removal and subsequent termination of parental rights regarding her first two children, the mother had three more children, including the child in this investigation. Shortly after his birth, in early 2022, this child and a sibling were sheltered from their mother. They were reunified in late 2022. In the spring of 2023, this child was admitted to the hospital with fatal head and neck injuries for which the mother provided implausible and inconsistent explanations. The child died from abusive head trauma resulting in a skull fracture, subdural hemorrhage, and severe brain and spinal cord injuries. This child's death was preventable: had DCF adequately considered the mother's 17-year record of documented abuse and violent behavior, this child would not have been returned to her care. This mother was charged with first degree murder.
5. **Child Abuse and Neglect Investigation, case #3:** For years, two siblings suffered physical and sexual abuse at the hands of their father, while their mother failed to protect them. Despite 9 reports filed by the children to DCF, every case was closed without DCF intervention. Out of desperation, both children requested to be Baker Acted simply to avoid returning home, yet they were continually sent back to the family home. Although the oldest child was finally sheltered from her father in the spring of 2016, the younger sibling was left in an abusive environment. In 2018, we note there was a recommendation that the father have no unsupervised contact with his children pending a polygraph regarding the sexual abuse allegations; nevertheless, no legal action was taken to protect the younger child until 2020. By that time, DCF discovered that this child had been abandoned and had not seen his parents in nearly two years. The prolonged trauma culminated in the fall of 2022 when the older child, encountering her father for the first time in six years, fatally shot and killed him. Ultimately, this tragic outcome represents a catastrophic failure to act on repeated reports and evident red flags. By ignoring repeated reports of physical and sexual abuse, DCF's inaction essentially abandoned these two vulnerable children.
6. **Child Abuse and Neglect Investigation, case #4:** Unlike most of the cases we have discussed, this case involved eight children who were removed from their homes by DCF and placed into foster care. From 2016 to 2020, temporary caregivers were approved

foster parents. During this time, there were 18 DCF investigations regarding the foster family. Despite these investigations, the adoption (to these same foster parents) of all eight children was finalized in 2020. The adoptive mother passed away shortly after the adoption proceedings were finalized, leaving the adoptive father in sole custody of the eight children through 2026. After the adoption there were an additional 37 DCF reports which involved concerns relayed by relatives, medical professionals, counselors, and school employees. These reports documented alarming allegations, including physical, emotional, and sexual abuse, substance misuse, bizarre punishment, and parental hallucinations. Notwithstanding persistent concerns highlighted in DCF's reports, such as inconsistent injury explanations, coached or rehearsed statements, and repeated disclosures of abuse, investigations yielded minimal action. Disclosures were frequently recanted during interviews conducted in the presence of the adoptive parents or under the immediate threat of return to their custody. Consequently, reports were routinely screened out, closed without intervention, or resulted in only temporary removal before returning children to the home. This multi-year oversight culminated in the adoptive father's 2026 arrest for sexual offenses against the eldest child.

In each of the cases outlined in this report, the writing was on the wall, yet DCF still failed these children and vulnerable adults. These failures have led to an immeasurable amount of trauma and unnecessary death. The seven cases we thoroughly reviewed are a small sample of the issues facing DCF Circuit 5.

IV. Additional Findings

Finally, we found that DCF is often unprepared in court, frequently does not follow court orders, and does not take advantage of certain statutory avenues to protect children from harm. We note this occurs, in part, because of the secrecy in which this entire process operates. In fact, most court hearings are confidential and DCF paperwork/reports are confidential, with very few exceptions. It is clear the judge is the only line of defense, yet has no real power to fix or punish breaches of DCF's responsibilities. Deadlines are laid out in the statutes, but there is no recourse for families, or courts, when they are missed by DCF. Further, because of the layers of bureaucracy, the blame as to "who" is responsible is designed to be ever shifting.

This grand jury also learned about twelve cases across the circuit where DCF or case management workers were accused by law enforcement of falsifying reports/records. This revelation was unnerving. These reports detailed documentation of telephone conversations which never occurred, home visits that never occurred, and interviews with families and children that never occurred. The investigations further revealed lack of training, established guidelines, and defined duties for these case managers. In eight out of the twelve cases, charges for official misconduct - falsifying records were filed by the State Attorney's Office.

V. Acknowledgements

We also think it is important to recognize the good work that members of our community have undertaken to provide services where DCF has failed. Specifically, all of the agencies involved in the co-responder program discussed earlier. Their time, resources, and emotional investment are commendable and speak directly to their care for the community they serve. The effectiveness of any agency is grounded in the commitment of its people to serve. This is true at all levels, for all agencies. We also recognize that the law enforcement community in the Fifth Circuit, as well as all of the first responder agencies, should be commended for going above and beyond the call of duty.

For purposes of clarity, we think it is important to note that the community-based care services differ from the duties and responsibilities of DCF. After a report comes into DCF through the abuse hotline, DCF is assigned to investigate. DCF determines whether a child remains at home with its parents, is placed with a relative, or is removed through the court system. Depending on DCF's decision, community-based case management agencies then step in to provide certain services. We learned that these community-based case management agencies are bound by the provisions set out by DCF in the initial assessments. They have no power to remove or shelter children. The primary purpose of creating community-based care was so each county can better meet the needs of its citizens, rather than a statewide blanket approach. In theory, this idea works. But on the front lines, the resources and services are clearly lacking. The community-based care services were candid with this grand jury about the limitations they face. They suffer from limitations and deficits in finding foster families and the overall resources they need to effectively provide services to families in need. We commend them for being cooperative with this investigation so that we, the grand jury, have a clearer picture of who is ultimately responsible, what can be put into the category of ineptitude, and what may be due to a lack of resources.

CONCLUSION

Understanding our responsibilities as an investigating body, as well as our obligation to ensure that our report is fair and accurate, we invited six DCF employees at various levels to explain their process and address our concerns. Unfortunately, each of the invitations were declined or went unanswered. This is particularly disappointing, considering they are the primary agency that could have shed light on this critical investigation. We also want to emphasize that while our report is extensive, these results reveal only a fraction of the total scope of DCF Circuit 5's issues. We close by saying we believe our report speaks for itself. The facts and circumstances we encountered during our investigation lead us to make the following recommendations, which should be given serious consideration and have been crafted carefully and purposefully to improve the quality of life for the citizens of Circuit 5.

RECOMMENDATIONS

1. We recommend that any person who administers a mental capacity evaluation on a vulnerable adult must be properly trained on how to perform such evaluation.
2. We recommend that any mental capacity evaluation for a vulnerable adult must be interpreted by a trained and qualified medical professional.
3. We recommend requiring a secondary caregiver if the primary caretaker is unfit or indisposed.
4. We recommend a similar mental capacity evaluation of any person who is the sole caretaker of a vulnerable adult to determine if they are capable of caring for someone who is a vulnerable adult.
5. We recommend a mental capacity evaluation of any caretaker of a child once a DCF report has been made through the hotline and meets criteria for investigation.
6. We recommend mandating body cameras for all abuse or neglect interviews, home studies, and home visits for children and vulnerable adults.
7. We recommend all-encompassing digital tracking for each caseworker to document their duties.
8. We recommend supervisors conduct random audits on caseworkers to ensure compliance with all DCF rules and regulations.
9. We recommend a full evaluation of the way that interviews of potentially abused, abandoned, or neglected children are conducted. These children should not be interviewed in the presence or same location as the accused or under the immediate threat of being returned to such individuals.
10. We recommend mandating that any case manager document the conditions of the home and the child through photographs.
11. We recommend that any abuse or neglect reports that originate from certain officials, such as school employees, law enforcement, medical professionals, and counselors require mandatory investigations by DCF and be given expedited status.
12. We recommend that any family that is considered a high utilizer of DCF services (meaning two or more prior complaints of a similar nature), whether related to a child or vulnerable adult, be assigned to a supervisor and mandate an expedited investigation. This will ensure consistency and account for high turnover.
13. We recommend that all training provided by DCF, or its subcontractors, be required to be completed within a certain period of time of employment, regardless of absences.
14. We recommend that all Adult and Child Protective Investigators receive additional training, including, but not limited to criminal justice, medical training, indicators of abuse, and investigative techniques.
15. We recommend that a determination be made based on an accumulation of reports, rather than the most recent allegation. We observed that DCF often made conclusions based on a single report without giving weight to prior allegations.

16. We recommend that if an allegation has previously been reported, and closed, any subsequent report including that prior allegation must still be investigated to ensure there is no new information.
17. We recommend that a hospital cannot be used as an excuse by DCF to shirk their responsibilities to provide placement or provide services for vulnerable adults.
18. We recommend that if a vulnerable adult is taken to the hospital, DCF is still responsible for finding safe placement upon release, and/or implement an appropriate safety plan.
19. We recommend expanding capacity for temporary and permanent placement options for children and vulnerable adults.
20. We recommend that there should be parity for services between children and vulnerable adults.
21. We recommend that any placement for children and vulnerable adults cannot be outside their jurisdiction or must be within a defined geographic region.
22. As a grand jury we noticed that calls that come in after hours where children or vulnerable adults are in unsafe conditions, are often not responded to in accordance with the law. We recommend that failure to comply with DCF policies and the law result in sanctions and there be some form of public accountability and oversight into the process.
23. We further recommend that failure to comply with time constraints as outlined in Florida statutes or court orders result in sanctions.
24. We recommend that payments to foster or adoptive parents who are under investigation by DCF or law enforcement be scrutinized or reevaluated by the legislature.
25. We recommend a top-down financial audit of DCF Circuit 5.
26. We recommend reevaluating and expanding funding for vulnerable adults and children in Circuit 5.
27. We recommend revising the 60-day case closure deadline.
28. We recommend people seeking eligibility to be adoptive parents, and who have a certain number of prior DCF investigations, be disqualified.
29. We recommend that the required educational background be reevaluated and consider requiring a four-year degree in social work, psychology, criminal justice, public health, or early childhood education.
30. We recommend at least two random drug screens per month for caregivers, parents, and foster parents who are actively involved in a DCF investigation.
31. We recommend that if you have had one child previously removed from your custody, there is an automatic presumption that you are unfit for any subsequent child until proven otherwise.
32. We recommend more transparency and oversight in DCF Investigations and court proceedings.
33. We recommend coordination between DCF circuits and the State to ensure proper resolution of cases that cross county or jurisdictional borders.
34. We recommend that the legislature revisit immunity.

Respectfully submitted,

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Cindy Armstrong, Vice Foreperson
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ATTEST:

Carol Heeley
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Date: August 27, 2026