The South Carolina Court of Appeals

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September 08, 2022

The Honorable David Hamilton
PO Box 649
York SC 29745-0649

REMITTITUR

Re: Elizabeth Hope Rainey v. SCDSS
Lower Court Case No. 2011CP4604508
Appellate Case No. 2017-001367

Dear Clerk of Court:

The above referenced matter is hereby remitted to the lower court or tribunal. A copy of the judgment of this Court is enclosed.

Very truly yours,

V Claire Allen

CLERK

Enclosure

cc: Whitney Boykin Harrison, Esquire
S. Randall Hood, Esquire
Lara Pettiss Harrill, Esquire

Jordan Christopher Calloway, Esquire
Duane Michael Shaw, Esquire
Nathan James Sheldon, Esquire
Patrick John Frawley, Esquire
The Honorable S. Jackson Kimball, III

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen C., a minor, Appellant,

v.

South Carolina Department of Social Services, Respondent.

Appellate Case No. 2017-001367

Appeal From York County
S. Jackson Kimball, III, Special Circuit Court Judge

Opinion No. 5838
Heard October 10, 2019 – Filed July 21, 2021

REVERSED IN PART, VACATED IN PART, AND REMANDED

Duane Michael Shaw, of Shaw Law Firm of Rock Hill; S. Randall Hood and Jordan Christopher Calloway, both of McGowan Hood & Felder, LLC, of Rock Hill; Whitney Boykin Harrison, of McGowan Hood & Felder, LLC, of Columbia; Nathan James Sheldon, of The Law Office of Nathan J. Sheldon, LLC, of Rock Hill; and Lara Pettiss Harrill, of Lara Pettiss Harrill, P.C., of Spartanburg; all for Appellant.

Patrick John Frawley, of Davis Frawley, LLC, of Lexington, for Respondent.

MCDONALD, J.: In this action alleging gross negligence, Elizabeth Hope Rainey (Guardian) challenges the circuit court's granting of summary judgment to the South Carolina Department of Social Services (DSS). Rainey argues the circuit court applied an incorrect gross negligence standard to find DSS exercised slight care during its investigation of infant Owen C.'s abuse and neglect case. She further asserts the circuit court improperly weighed the evidence in addressing proximate cause. We reverse in part, vacate in part, and remand to the circuit court for further proceedings.

Facts and Procedural History

Nineteen-year-old Mother and eighteen-year-old Father lived together with their infant son (Child). When Child was twelve weeks old, Mother and Father began to notice changes in his behavior—he was sleeping more and screaming while awake. They took Child to a twenty-four-hour clinic on November 28, 2009, but the doctor could not find anything wrong with him. On December 2, Mother and Father took Child to the pediatrician because Child had a strange odor coming from his mouth, was sleeping more, and did not seem like himself. The pediatrician diagnosed him with a viral infection and instructed Child's parents to give him Tylenol every six hours.

On December 4, Father was watching Child when, according to Father, Child screamed, arched his back, turned red, and "went limp." Father was home alone with Child when this occurred, but Mother returned just after the incident, and the couple took Child to the emergency room at Piedmont Medical Center (PMC) in Rock Hill. PMC staff noted Child was "lethargic, not responsive, and we thought he was dead." However, PMC staff also described Child as "well appearing; well nourished; in no apparent distress . . . a 'great' looking child very healthy." Mother and Father denied dropping Child and claimed they were unaware of any traumatic event that might explain Child's injuries or lethargic behavior.

On December 5, PMC transferred Child to Levine Children's Hospital at Charlotte-Mecklenburg Hospital Authority (Levine). Child's December 6th CT scan revealed two subdural hematomas—brain bleeds—which raised suspicions of a non-accidental injury. However, Child's treating physician declined to opine whether the infant's injuries were accidental or non-accidental.

On December 6, a Levine social worker reported Child's injuries to DSS. When the on-call caseworker, Chandra Tyler, arrived at Levine to speak with Child's family, the nurse "seemed confused and said that they had no known concerns of

non-accidental trauma. . . ." After Tyler spoke with Mother and Father, the couple and Child's maternal grandmother entered a voluntary safety plan with DSS and received a brochure regarding child protective services. The initial safety plan provided DSS would intermittently monitor the home and communicate with Mother and Father, who were prohibited from removing Child from the hospital until DSS approved his discharge.

On December 7, Child's DSS case was assigned to caseworker Dirvondra Hill and her supervisor, Krista Hinnant, who staffed the case with Tyler and her supervisor, Lola Sutherland. Hinnant spoke with a Levine social worker, who told her hospital staff could not determine whether Child's injuries were accidental or non-accidental and "that while the hospital could not rule out trauma, the family had no clear history of trauma, and the hospital's concerns were mostly for lack of supervision." After staffing the case with the York County DSS legal department, Hinnant told caseworker Hill to refer the matter to law enforcement and informed Levine that Child should be discharged to Mother and Father; DSS would then follow up with a home assessment. Pursuant to this instruction, the hospital discharged Child to his parents. At the time of Child's discharge, there was no explanation for the cause of Child's brain bleeds.

Hill failed to refer the matter to law enforcement as instructed; however, later on December 7, she attempted to meet with Mother and Father at their home. Hill again went to the home on December 8 and December 10, but found no one present for either of these unannounced visits. Hill then mailed the parents a letter scheduling a home visit for December 21.

After business hours on December 16—ten days after the hospital discharged Child to his parents—Hill faxed the referral reporting the possible abuse of infant Owen C. to the York County Sheriff's Department (YCSD). Upon receiving the fax when he arrived at work the next morning, Lieutenant W. J. Miller contacted DSS to gather additional information and find out why law enforcement was not called the same night Child's bleeding on the brain was reported. In his conversation with supervisor Sutherland, Lt. Miller expressed his frustration with DSS's failure to contact law enforcement within the statutorily mandated twenty-four-hour period.[1] Sutherland initially attempted to minimize the situation, explaining:

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[1] Section 63-7-980(B)(1) of the South Carolina Code (2010) requires that where facts "indicating abuse or neglect also appear to indicate a violation of criminal law, the department must notify the appropriate law enforcement agency of those facts within twenty-four hours of the department's finding for the purposes of

> So, the baby's had four other–not hospital, but doctor visits, and the doctor has continuously sent the child home. But the family has responded to the child appearing limp because the–Friday [December 4] the incident was the worst. So, no, I didn't send law enforcement out. Child was in a safe place [the hospital]. We had to get the information. We have to find out what's going on.

Sutherland then acknowledged she "made the call not to call law enforcement that night" and continued:

> I had 24 hours. And then it was being passed on to the next worker. So–but that baby's been to four different appointments prior to getting to Pineville. This did not—this appears to be something that's been going on since 11/30, and the parents kept taking the child to the doctor or to Riverview Clinic or then to the hospital. And they just kept getting turned around. "Everything's fine. Everything's fine." Except for the 4th. Friday the 4th, that–the hospital said, "No. Everything's not fine."

Sutherland next reviewed the case dictation notes with Lt. Miller, who then left a message for the caseworker's supervisor, Hinnant, to call him. When Hinnant called Lt. Miller, she reported she had staffed the case with DSS's counsel, who advised her to let the child go home as the hospital would not provide a determination that abuse had occurred. However, the DSS attorney further advised Hinnant to refer the matter to law enforcement. Hinnant acknowledged caseworker Hill "should've made [the law enforcement referral] as soon as she got the report when we staffed it from on-call" and told Lt. Miller she had "fussed at" Hill when she learned of the failure.

On December 17, Hill again visited the home and made contact with Mother, who acknowledged receipt of Hill's letter scheduling the home assessment for December 21. Mother reported Child was with his grandmother, who kept the baby while his parents were at work; however, Mother could not provide Hill with

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police investigation." DSS concedes it failed to notify YCSD within the statutorily-mandated time period.

a phone number at which the grandmother could be reached. On December 21, Hill conducted the scheduled home visit. Hill's computerized record entry notes report Hill observed Mother and Father's behavior with Child was appropriate.[2] Mother and Father told Hill they did not know how Child was injured in early December and he had not been dropped.

On January 4, 2010, Hill and Hinnant again staffed the case. The recommendations following the staffing were to gather all of Child's medical records, follow up with YCSD regarding the referral to law enforcement, and assess the grandmother's home.

On January 11, Child began seizing. Mother and Father took him to PMC; Child was then airlifted to Levine Children's Hospital. A CT scan revealed up to five new hematomas, in different areas than those observed on the early December CT scan. Child had an acute brain bleed, was actively seizing, and had multiple bruises on his body—his left leg, left hand, chest, and face were bruised. An ophthalmologist observed hemorrhaging and bleeding in the back of Child's eye. Child continued to suffer seizures for the next few days. After Mother chose to discontinue Child's medical care, he was taken off life support and admitted to a hospice facility in Rock Hill. Child has since been released from hospice; he survived, but has severe, permanent brain damage and vision problems.

Ultimately, Father admitted to harming Child. In 2011, he pled guilty to inflicting great bodily injury on a child and unlawful conduct toward a child, for which he received an eight-year sentence.

On December 1, 2011, Guardian filed this action against Levine, DSS, the York County Sheriff, YCSD, and York County. Among other claims, Guardian alleged DSS was grossly negligent in failing to properly investigate after it received notice in early December 2009 of the potential abuse. With the complaint, Guardian filed the affidavit of George W. Savarese, a licensed clinical social worker, who opined DSS, along with certain law enforcement and medical defendants, committed negligent acts or omissions in the services and care rendered to Child, thus contributing to Child's injuries. DSS answered, denying liability and asserting the protections of the South Carolina Tort Claims Act[3] as affirmative defenses.

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[2] Hill conducted her scheduled home visit on December 21; she entered the computerized record entry notes three weeks later, on January 12.

[3] S.C. Code Ann. §§ 15-78-10 to -220 (2005 & Supp. 2020).

On September 9, 2013, DSS moved for summary judgment; however, it withdrew this motion while the case was stayed pending Guardian's appeal of the circuit court's order granting summary judgment to co-defendant Levine. By unpublished opinion filed April 22, 2015, this court affirmed the circuit court's grant of summary judgment to Levine. *Rainey v. Charlotte-Mecklenburg Hosp. Auth.*, No. 2015-UP-209 (S.C. Ct. App. filed Apr. 22, 2015). The supreme court denied Guardian's petition for a writ of certiorari on May 6, 2016.

On January 4, 2017, DSS re-filed its motion for summary judgment. DSS argued there was no genuine issue of material fact and it was entitled to judgment as a matter of law because its employees exercised at least slight care in handling Child's case. Following a hearing, the circuit court granted DSS's motion for summary judgment.

Guardian filed a Rule 59(e), SCRCP, motion to reconsider. After a hearing, the circuit court denied the Rule 59(e) motion.

Standard of Review

"In reviewing a grant of summary judgment, our appellate court applies the same standard as the trial court under Rule 56(c), SCRCP." *Woodson v. DLI Properties, LLC*, 406 S.C. 517, 528, 753 S.E.2d 428, 434 (2014). "Summary judgment is proper if, viewing the evidence and inferences to be drawn therefrom in a light most favorable to the nonmoving party, the pleadings, depositions, answers to interrogatories, admissions, and affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law." *Id.* "In determining whether summary judgment is proper, the court must construe all ambiguities, conclusions, and inferences arising from the evidence against the moving party." *Weston v. Kim's Dollar Store*, 399 S.C. 303, 308, 731 S.E.2d 864, 866 (2012) (quoting *Byers v. Westinghouse Elec. Corp.*, 310 S.C. 5, 7, 425 S.E.2d 23, 24 (1992)); *see also Est. of Mims v. S.C. Dep't of Disabilities & Special Needs*, 422 S.C. 388, 403–04, 811 S.E.2d 807, 815–16 (Ct. App. 2018) ("[I]n cases applying the preponderance of the evidence burden of proof, the non-moving party is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment." (quoting *Hancock v. Mid-S. Mgmt. Co., Inc.,* 381 S.C. 326, 330, 673 S.E.2d 801, 803 (2009))).

Law and Analysis

Guardian argues the circuit court erred in granting DSS's motion for summary judgment because genuine issues of material fact remain and the circuit court used an incorrect standard for determining gross negligence. Specifically, Guardian argues the circuit court erred in finding that based on the entire record, DSS employees exercised slight care in releasing Child back to his parents and investigating the report of his brain bleeds. Guardian submits *Bass v. South Carolina Department of Social Services*, 414 S.C. 558, 780 S.E.2d 252 (2015), "requires DSS to exercise slight care during each phase of its investigation, including the execution of any undertaking prescribed by statutes, policies/procedures, or guidelines."

Under the South Carolina Tort Claims Act, a government agency "is not liable for a loss resulting from . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity, except when the responsibility or duty is exercised in a grossly negligent manner." § 15-78-60(25). "'Gross negligence is the intentional conscious failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one ought not to do.' In other words, "[i]t is the failure to exercise slight care.'" *Bass*, 414 S.C. at 571, 780 S.E.2d at 258–59 (citations omitted) (quoting *Etheredge v. Richland Sch. Dist. One*, 341 S.C. 307, 310, 534 S.E.2d 275, 277 (2000)); *see also Clyburn v. Sumter Cnty. Sch. Dist. No. 17*, 317 S.C. 50, 53, 451 S.E.2d 885, 887 (1994) ("Negligence is the failure to exercise due care, while gross negligence is the failure to exercise slight care."). "Gross negligence has also been defined as a relative term, and means the absence of care that is necessary under the circumstances." *Bass*, 414 S.C. at 571, 780 S.E.2d at 259 (quoting *Etheredge*, 341 S.C. at 310, 534 S.E.2d at 277).

"Normally, the question of what activity constitutes gross negligence is a mixed question of law and fact. However, 'when the evidence supports but one reasonable inference, the question becomes a matter of law for the court.'" *Id.* (citation omitted) (quoting *Etheredge*, 341 S.C. at 310, 534 S.E.2d at 277). Because the evidence in this case supports the reasonable inference that DSS failed to exercise slight care from the outset of its investigation regarding Child's injuries, the circuit court erred in granting summary judgment.

Within twenty-four hours of receiving a report of possible abuse or neglect, DSS is required to begin an investigation into child abuse allegations to determine whether the report is "indicated" or "unfounded." S.C. Code Ann. § 63-7-920(A)(1) (2010). DSS must make a finding of "indicated" or "unfounded" within forty-five days of

receiving the report, but a fifteen-day extension may be granted if good cause is shown. S.C. Code Ann. § 63-7-920(A)(2) (2010). "Indicated findings must be based upon a finding of the facts available to the department that there is a preponderance of evidence that the child is an abused or neglected child." S.C. Code Ann. § 63-7-930(B)(1) (2010).

> Where the facts indicating abuse or neglect also appear to indicate a violation of criminal law, the department must notify the appropriate law enforcement agency of those facts within twenty-four hours of the department's finding for the purposes of police investigation. The law enforcement agency must file a formal incident report at the time it is notified by the department of the finding.

S.C. Code Ann. § 63-7-980(B)(1) (2010).

In *Bass*, DSS received a report that two autistic children were possibly poisoned by their parents when the children became ill after taking their sleep medication. 414 S.C. at 563, 780 S.E.2d at 254. When the DSS caseworker responded to the report, she found the bottle of sleep medicine but did not have it tested or otherwise investigate the contents of the bottle. *Id.* at 564, 780 S.E.2d at 254. Four days later, DSS determined the children should be removed from the home and placed with their aunt. *Id.* at 564, 780 S.E.2d at 254–55. Approximately one month later, the pharmacy that compounded the medicine called the children's mother to report it had improperly mixed the prescription at one thousand times the recommended concentration. *Id.* at 563–65, 780 S.E.2d at 254–55. DSS determined the children could return home; however, it refused to remove from its files the finding that parents "harmed their children." *Id.* at 564–65, 780 S.E.2d at 255. The parents filed an action against DSS and the pharmacy, ultimately settling with the pharmacy. *Id.* at 565, 780 S.E.2d at 255. At trial, the jury awarded the parents $4,000,000 in damages against DSS. *Id.* at 568, 780 S.E.2d at 257. The court of appeals reversed, finding the trial court erred in denying DSS's motion for judgment notwithstanding the verdict (JNOV) because there was no evidence DSS was grossly negligent in its investigation. *Id.* at 569, 780 S.E.2d at 257. However, our supreme court reversed this court, finding sufficient evidence of gross negligence in DSS's post-removal investigation to present a jury question. *Id.* at 571, 780 S.E.2d at 258. The court noted the expert witness testified as to the proper standard of care and provided specific instances of DSS's breach of such. Moreover, DSS employees testified about DSS's failure "to conduct *any* investigation into the medication during its post-EPC investigation." *Id.* at 574,

780 S.E.2d at 260. The supreme court found DSS was not grossly negligent in initially removing the children, noting the time constraints and exigent circumstances associated with Emergency Protective Custody (EPC) removal, and emphasized that its "opinion should not be read to impose on DSS a duty to conduct the post-EPC investigation in a pre-EPC setting." *Id.* at 571, 780 S.E.2d at 258.

Here, the fact that DSS did not refer the allegations to law enforcement within twenty-four hours as required by statute raises a question as to whether DSS exercised slight care in investigating the possible abuse and neglect of an infant with two unexplained subdural hematomas. *See* § 63-7-980(B)(1) (requiring DSS to refer allegations of child abuse to law enforcement within twenty-four hours of receiving the report); *Bass*, 414 S.C. at 571, 780 S.E.2d at 259 ("Normally, the question of what activity constitutes gross negligence is a mixed question of law and fact. However, 'when the evidence supports but one reasonable inference, the question becomes a matter of law for the court.'") (citation omitted) (quoting *Etheredge*, 341 S.C. at 310, 534 S.E.2d at 277)). Hill failed to make the law enforcement referral for ten days, despite her supervisor's earlier specific instruction to make the referral. While this alone might not establish a failure to exercise slight care, other evidence in the record raises concerns that present questions for a jury with regard to whether DSS exercised slight care in investigating Child's abuse.[4]

DSS argues the circuit court's proximate cause ruling further supports the grant of summary judgment. The circuit court's summary judgment order addresses proximate cause in a footnote, stating:

> One concrete example Plaintiff cites as a violation of the applicable standard of care is the fact that DSS did not notify law enforcement of DSS's involvement in the case, and the investigation of the report by the hospital, within twenty-four hours of notification to DSS. While DSS

[4] Some of these concerns are set forth in the affidavit of George Savarese, Ph.D., plaintiff's expert in clinical social work, who opined DSS employees breached the standard of care applicable to licensed social workers in failing to "initiate and facilitate an appropriate discharge plan" or "comprehend the specifics of the risk for child abuse and re-injury related to Owen." *See e.g.*, *Bass*, 414 S.C. at 574, 780 S.E.2d at 260 (reversing this court's finding that plaintiff's expert's opinion lacked a sufficient evidentiary basis and inaccurately portrayed the standard of care).

> failed to carry out this mandate, law enforcement was notified and had an opportunity to investigate the case. Law enforcement took no action on the case prior to the severe injury of Owen by his father. Thus, while DSS did not act within the prescribed time to notify law enforcement, that failure was not the proximate cause of the tragic injury to Owen.

This proximate cause ruling is problematic when considered within the context of whether DSS exercised slight care in communicating to law enforcement the nature of the hospital staff's concerns regarding the cause of Child's subdural hematomas. Specifically, the transcripts of the DSS supervisory staff's phone calls with Lt. Miller are troubling. When Lt. Miller first asked why DSS had not alerted the YCSD on the night Child's initial brain bleed was discovered, on-call supervisor Sutherland hedged, noting Child was safe at the hospital and four different doctors had "continuously sent the child home." Lt. Miller was most concerned because Child's parents claimed to have no knowledge of any fall or other head injury suffered by Child, yet Child had gone limp, was not acting normally, and had suffered an injury to the falx area of his brain.[5]

Sutherland read Miller DSS's staffing notes so he could follow up on his call to caseworker Hill's supervisor, Hinnant. However, when Hinnant called Lt. Miller, she, too, minimized the possibility that the baby had been abused. Hinnant told Miller of a prior shaken baby case in which three separate episodes occurred "before the doctors would say it is because of this and, you know, give us enough

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[5] "Subdural hematomas that are located between the two hemispheres are most suspicious for an abusive etiology. These are known as interhemispheric or falcine hematomas, or, if between the two infolding layers of dura that comprise the falx, as interdural hematomas." Thomas D. Lyon et. al., *Medical Evidence of Physical Abuse in Infants and Young Children*, 28 Pac. L.J. 93, 156–57 (1996) (explaining that "[a] subdural hematoma in a previously healthy infant with no history of trauma, or with a history of minor trauma, is highly suggestive of abuse. Subdural hematomas are both a common pathologic consequence of shake-impact events and a relatively uncommon consequence of other types of trauma and disease").

to remove the child from the home. But in this case they're not. They don't have any suspicions."

This was not an accurate account of hospital staff's concerns. A note from DSS's December 7 "Case Transfer and/or Case Staffing" process reflects concerns that "Owen has two subdural hematomas. One would indicate non accidental trauma. Parents appropriate." Additional notes discuss Child's prior medical visits. The first page then concludes, "[Social worker] has concerns [because] CT scan shows non-accidental trauma. No [doctor] is saying it [illegible] non-accidental." A DSS Legal Staffing document that same day titled "Case Transfer and/or Case Staffing," notes: "Baby in hospital. Two subdural hematomas. Unknown how baby received. Hospital cannot determine if accidental or non-accidental."[6]

In basing its proximate cause ruling on a finding that "[l]aw enforcement took no action on the case prior to the severe injury of Owen by his father," the special circuit court failed to consider evidence that DSS conveyed conflicting information to Lt. Miller in response to his effort to investigate the cause of Child's injuries. A reasonable jury could find that the late law enforcement referral and the tenor of the DSS supervisors' conversations with Lt. Miller influenced YCSD's investigation−specifically, its consideration of the risk Child faced once the hospital released him to his parents. *See e.g.*, *Madison ex rel. Bryant v. Babcock Ctr., Inc.*, 371 S.C. 123, 147, 638 S.E.2d 650, 662 (2006) (reversing grant of summary judgment and explaining a "defendant's negligence does not have to be the sole proximate cause of the plaintiff's injury; instead, the plaintiff must prove the defendant's negligence was at least one of the proximate causes of the injury. The question of proximate cause ordinarily is one of fact for the jury, and it may be resolved either by direct or circumstantial evidence. The trial judge's sole function regarding the issue is to inquire whether particular conclusions are the only reasonable inferences that can be drawn from the evidence." (citations omitted)); *Est. of Mims v. S.C. Dep't of Disabilities & Special Needs*, 422 S.C. 388, 403, 811

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[6] This court recognized the suspicions of Levine's medical team, as reflected in Child's medical records and DSS's staffing notes, in Guardian's initial appeal. *See Rainey v. Charlotte-Mecklenburg Hosp. Auth.* at *2-3 (noting Levine hospital staff "thoroughly tested Child for physical evidence of abuse. The results of these tests were inconclusive as to whether Child had been abused" and it was undisputed that the hospital "complied with the reporting statute, S.C. Code Ann. § 63-7-310 (amended June 8, 2010), when a staff member contacted DSS regarding suspected abuse or neglect of Child").

S.E.2d 807, 815 (Ct. App. 2018) (where multiple inferences may be drawn from the evidence presented at summary judgment, a jury must resolve the question of proximate cause). Accordingly, we vacate the special circuit court's proximate cause finding.

We recognize DSS had until January 20—forty-five days after receiving the report on December 6—to conduct its investigation in this case. *See* § 63-7-920(A)(1). Child's severe injuries occurred on January 11, within DSS's forty-five day investigatory period. Even though caseworker Hill did not refer the allegations to law enforcement until December 16, Hill attempted to make contact with Mother and Father several times during that period and sent a letter scheduling the home assessment for December 21. After sending the letter, Hill visited the home on December 17 and made contact with Mother, who confirmed she received the letter scheduling the upcoming visit.

DSS dictation notes indicate Hill conducted the scheduled home visit with the family on December 21.[7] Her notes provide the following observations:

> [Father] stated the baby was normal now and has not had any concerns/problems since [the early December hospitalization]. He stated he does not know how the

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[7] Hill did not input this critical dictation note until January 12, 2010—after DSS learned Child had been readmitted to the hospital and the ophthalmologist reported "there was hemorrhaging and bleeding at the back of the eye." DSS received the ophthalmologist's call at 7:20 p.m. on January 11; Hill entered the dictation note for this call the following morning at 7:28 a.m. At 7:23 a.m. on the 12th, Hill entered another dictation note from the evening of the 11th, reflecting that at 6:15 p.m., "Doctor Timmons reported there was brain tissue dead and caused a stroke. Doctor informed case manager there was a history of head bleeds." Other calls categorized as "Collateral Contacts" from the 11th were input on the afternoon of the 11th and the morning of the 12th—which is perfectly reasonable. However, it was not until the morning of the 12th—at 9:56 a.m.—that Hill entered the note reporting the December 21 home visit at which she observed Child was "vibrant", "kicking," "laughing," and "smiling." Hill entered two notes for December 10 on January 13, despite her entering of a December 8 note on December 16. This pattern of recordkeeping raises further questions of fact and of credibility necessitating review by a jury, particularly when considered in conjunction with the telephone call transcripts.

> baby received the injury [and] they are glad the baby is better. [Father] played on the floor with the baby as the caseworker as case manager spoke to them. [Child] was vibrant lying on his back on a blanket kicking his feet and arms laughing and smiling as his father interacted with him . . . . Case manager inquired about discipline—parents stated they do not discipline the child because the baby does not know any better and he's just a baby.

DSS argues Hill's repeated attempts to make these unannounced home visits provide evidence in support of the circuit court's "slight care" analysis, but a jury could find the attempted visits demonstrate the opposite. When considered with the inferences that arise from the caseworker's pattern of recordkeeping—along with DSS's failure to make a timely, accurate referral to law enforcement and alleged failure to conduct a proper risk determination analysis prior to and after authorizing the hospital to release Child back to his parents—a jury could reasonably determine that this lack of contact with Child is further evidence of DSS's failure to exercise slight care in conducting the Owen C. investigation. The sum of these problems, when considered at the various stages of DSS's evaluative and investigative processes, presents the classic "mixed question of law and fact" requiring a jury's determination on the question of gross negligence. *See Proctor v. Dep't of Health & Env't Control*, 368 S.C. 279, 309, 628 S.E.2d 496, 512 (Ct. App. 2006) ("In most cases, gross negligence is a factually controlled concept whose determination best rests with the jury.").

Thus, we reverse the circuit court's order granting summary judgment, vacate the proximate cause finding, and remand this matter for further proceedings.

REVERSED IN PART, VACATED IN PART, AND REMANDED.

HUFF and WILLIAMS, JJ., concur.