THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Unpublished Opinion No. 2015-UP-209
Appellate Case No. 2013-002058

RECEIVED
APR 21 2016
S.C. SUPREME COURT

Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted] a minor.....Petitioner,

v.

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department Of Social Services and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, the York County Sheriff's Department, and York County

Of whom

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center is..... Respondent.

Appendix

Volume of I of III

Monty Todd
Robert Horner
Sowell Gray
P.O. Box 11449
Columbia, SC 29211
(803) 929-1400

ATTORNEYS FOR RESPONDENT

S. Randall Hood
Deborah G. Casey
Lara Pettiss Harrill
Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800

ATTORNEYS FOR PETITIONER

INDEX

Court of Appeals Opinion 1

Order Denying Petition for Rehearing 7

Petition for Rehearing 9

Return 19

(Materials from the Record on Appeal)

Orders

Order Granting Summary Judgment, dated May 13, 2013 29

Form 4 Order Denying Plaintiff's Motion to Alter or Amend Judgment, dated August 14, 2013 40

Forms and Pleadings

Summons and Complaint 42

Answer of Defendant Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center 72

Amended Answer of Defendant Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center 79

Answer of the Defendant South Carolina Department of Social Services 85

Transcripts

Transcript of Record, hearing date April 18, 2013 92

Transcript of Hearing, hearing date August 14, 2013 145

Motion and Memorandums

Notice of Motion and Motion for Summary Judgment 198

Memorandum in Support of Motion for Summary Judgment 202

Plaintiff's Memorandum of Law in Opposition to Defendant Charlotte-Mecklenburg Hospital Authority's Motion for Summary Judgment 212

Affidavit of Dr. George W. Savarese, LCSW 234

Exhibit 1—Savarese Curriculum Vitae 268

Exhibit 2—National Association of Social Workers ("NASW") Code of Ethics 2008 276

Exhibit 3—NASW Clinical Social Work in Social Work Practice 2005 294

Exhibit 4—NASW Social Work Practice in Health Care Settings 2005 319

Exhibit 5 –NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital 358

Exhibit 6—CMHA Policy PR 110.03 Juveniles Suspected of Being Abused or Neglected 367

Exhibit 7—Evaluation of Suspected Child Physical Abuse 2007 391

Exhibit 8-23—Medical and DSS Records for [redacted] 406

Exhibit 24—Transcript of Phone Call between York County DSS and the York County Sheriff's Office, dated December 17, 2009 ... 459

Exhibits 25-26—Medical Records for [redacted] (Dec. 2009) Hospitalization 472

Exhibit 27—Excerpt from Deposition of Briggs E. Cook, M.D. 477

Exhibit 28—CMHA Policy PR 110.03, Child Abuse and Neglect Algorithm 479

Exhibits 29-32— Medical Records for [redacted] (Dec. 2009) Hospitalization 481

Exhibit 33—Transcript of Phone Call between York County DSS and the York County Sheriff's Office, dated January 19, 2010 491

Exhibits 34-35—DSS Case Dictation (January-February 2010) 497

Exhibits 36-37—Medical Record for [redacted] (January-February 2010) 502

Exhibit 38—South Carolina DSS Record (January 2010) 506

Exhibit 39—Excerpts from Deposition of Laura Newmark, MSW 508

Exhibit 40—Excerpts from Deposition of Cheryl Courtlandt, M.D. ... 521

Exhibit 41—Excerpts from Deposition of Dirvondra Hill 530

Exhibit 42—Excerpts from Deposition of Krista M. Hinnant 533

Exhibit 43—Excerpts from Deposition of Larry Williams 538

Exhibit 44—Excerpts from Deposition of Charlotte Williams 543

Exhibit 45—Excerpts from Deposition of Kayla Lythgoe 548

Affidavit of J. Kevin Moore 556

Exhibit to Moore Affidavit 562

Plaintiff's Motion for Reconsideration and Memorandum in Support of Motion ... 631

Defendant the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center's Memorandum in Opposition to Plaintiff's Motion for Reconsideration 643

Deposition of Cheryl Courtlandt 648

Deposition of Krista M. Hinnant 690

Deposition of Kayla Lythgoe 805

Deposition of Laura Newmark 861

Deposition of Charlotte Williams 902

Notice of Appeal 944

(Materials from the Supplemental Record on Appeal)

Deposition of Larry Williams..... 967

Deposition of Dirvondra Hill 1126

(Briefs)

Appellant's Final Brief..... 1130

Respondent's Final Brief..... 1170

Appellant's Reply Brief..... 1203

THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted], a minor, Appellant.

v.

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, South Carolina Department of Social Services, Bruce Bryant, as the Constitutional Office of the Sheriff of York County, the York County Sheriff's Department, and York County, Defendants,

Of whom Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center is the Respondent.

Appellate Case No. 2013-002058

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

Unpublished Opinion No. 2015-UP-209
Heard March 2, 2015 – Filed April 22, 2015

AFFIRMED

S. Randall Hood, Lara Pettiss Harrill, Jordan Christopher Calloway, and Deborah G. Casey, all of Rock Hill, and Whitney Boykin Harrison, of Columbia, all of McGowan, Hood & Felder, LLC, for Appellant.

Monteith Powell Todd and Robert E. Horner, of Sowell Gray Stepp & Laffitte, LLC, of Columbia, for Respondent.

PER CURIAM: In this negligence action, Appellant Elizabeth Hope Rainey seeks review of the circuit court's order granting summary judgment to Respondent Charlotte-Mecklenburg Hospital Authority d/b/a/ Carolinas Medical Center. Appellant assigns error to the circuit court's refusal to conclude that Respondent had a duty to assess the home environment of Respondent's infant patient (Child), before he was discharged from Respondent's care. We affirm.

"An essential element in a cause of action based upon negligence is the existence of a legal duty of care owed by the defendant to the plaintiff. Without a duty, there is no actionable negligence." *Oblachinski v. Reynolds*, 391 S.C. 557, 561, 706 S.E.2d 844, 845-46 (2011); *see also Steinke v. S.C. Dep't of Labor, Licensing & Regulation*, 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999) ("In a negligence action, a plaintiff must show that the (1) defendant owes a duty of care to the plaintiff, (2) defendant breached the duty by a negligent act or omission, (3) defendant's breach was the actual and proximate cause of the plaintiff's injury, and (4) plaintiff suffered an injury or damages."). "An affirmative legal duty [of care] . . . may be created by statute, contract relationship, status, property interest, or some other special circumstance." *Jensen v. Anderson Cnty. Dep't of Soc. Servs.*, 304 S.C. 195, 199, 403 S.E.2d 615, 617 (1991).

Here, Appellant asserts that Respondent had a common law duty to assess Child's family environment before he was discharged from Levine Children's Hospital (Levine), part of Carolinas Medical Center, and then abused by his father. Appellant argues this duty arose out of either (1) the special relationship between Respondent and Child, or (2) Respondent's voluntary undertaking of a psychosocial assessment of Child. We address these alternative grounds in turn.

A. Special Relationship

Appellant argues that the special relationship between Respondent and Child gave rise to Respondent's duty to (1) assess Child's home environment, (2) communicate with the York County division of the South Carolina Department of Social Services (DSS) regarding Respondent's assessment, and (3) potentially intervene on Child's behalf. In support of her argument that a special relationship existed

between Respondent and Child, Appellant cites *Madison ex rel. Bryant v. Babcock Center, Inc.*, 371 S.C. 123, 638 S.E.2d 650 (2006) and *Niece v. Elmview Group Home*, 929 P.2d 420 (Wash. 1997). In both of these cases, the defendants were providers of residential care for disabled persons and the plaintiffs were living in these residential care settings at the time of the alleged breach of duty. *See Madison*, 371 S.C. at 137, 638 S.E.2d at 657 (holding that a non-profit corporation providing housing and other services for people with mental disabilities had a special relationship with a mentally disabled woman admitted for care and treatment at the corporation's facility); *Niece*, 929 P.2d at 427 ("[T]he special relationship between a group home for the developmentally disabled and its vulnerable residents creates a duty of reasonable care, owed by the group home to its residents, to protect them from all foreseeable harms . . . ."). Likewise, in at least one other jurisdiction, a hospital has been held to have a special relationship with its patient during the time the patient is hospitalized. *See Panion v. United States*, 385 F. Supp. 2d 1071, 1090 (D. Haw. 2005) (holding that the United States had a special relationship with the plaintiff given her status as a patient at an army hospital); *id.* (holding that the United States assumed a custodial role by admitting the plaintiff to the army hospital and the medical intensive care unit).

However, all of these cases are distinguishable from the present case because Appellant does not challenge the quality of care Respondent provided to Child during his four-day hospitalization in December 2009. In addition to stabilizing Child's condition, Respondent's staff thoroughly tested Child for physical evidence of abuse. The results of these tests were inconclusive as to whether Child had been abused. Further, it is undisputed that Respondent complied with the reporting statute, S.C. Code Ann. § 63-7-310 (2010) (amended June 8, 2010), when a staff member contacted DSS regarding suspected abuse or neglect of Child.[1] Rather, Appellant is essentially asking this court to impose on all hospitals a common law duty to protect a juvenile patient from third persons who might harm him after he has been discharged from a hospital's care. Our supreme court has not spoken on this precise issue, and we may not create such a common law duty. *See* Jean Hoefer Toal et al., *Appellate Practice in South Carolina* 12-13 (2d ed. 2002) ("The Court of Appeals is an error-correction court, whereas the Supreme Court is a law-

---

[1] We note our supreme court has held that there is no private cause of action under the predecessor to section 63-7-310. *See Doe v. Marion*, 373 S.C. 390, 399, 645 S.E.2d 245, 250 (2007) (concluding this court did not err in finding that section 20-7-510 of the South Carolina Code did not create a private cause of action).

giving court."). Accordingly, Appellant may not rely on Respondent's special relationship with Child as a ground for imposing liability for Child's injury.

B. Voluntary Undertaking

Alternatively, Appellant argues that Respondent's duty arose out of its voluntary undertaking of a psychosocial assessment of Child. In support of this argument, Appellant cites *Johnson v. Robert E. Lee Academy, Inc.*, 401 S.C. 500, 504, 737 S.E.2d 512, 514 (Ct. App. 2012), for the proposition that where an act is voluntarily undertaken, the actor assumes the duty to use due care. In *Johnson*, 401 S.C. at 504-05 & n.3, 737 S.E.2d at 514 & n.3, this court acknowledged South Carolina's previous adoption of the Restatement (Second) of Torts § 323, which states:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, *if*
>
> (a) his failure to exercise such care *increases* the risk of such harm, or
>
> (b) the harm is suffered because of the other's *reliance upon the undertaking.*

(emphases added).

Here, Respondent voluntarily employed professional social workers to "aid in the assessment process."[2] However, under section 323 of the Restatement, this

---

[2] Respondent also adopted a policy statement setting forth the procedures for hospital staff to follow in cases of suspected child abuse or neglect. However, at oral argument, Appellant's counsel conceded that Respondent's adoption of this policy, by itself, did not create a duty under section 323 of the Restatement. Rather, counsel argued, this policy statement was relevant to the standard of care. *See Madison*, 371 S.C. at 135, 638 S.E.2d at 656 (distinguishing the existence of a

undertaking cannot create a duty unless (1) the failure of Levine's staff to exercise reasonable care actually increased the risk of harm to Child or (2) Child suffered harm because he relied on this undertaking.

There is no evidence in the record showing that Levine's staff increased the risk of harm to Child—the evidence does not show that the social workers' participation in the assessment process caused DSS or law enforcement to perform a less thorough investigation than they would have otherwise. There is no evidence that DSS caseworkers omitted certain tasks from their investigations with the understanding that Levine's social workers would cover those tasks. Further, there is no evidence showing that Levine's social workers caused DSS to determine that Child's discharge to his parents was appropriate when DSS would not have otherwise made that determination.

Moreover, Child did not rely on Respondent's employment of social workers to assess Child. Rather, our legislature has designated DSS as the entity responsible for investigating a case of suspected child abuse or neglect within twenty-four hours of receiving a report. *See* § 63-7-310 (requiring certain persons to report suspected abuse or neglect to DSS or law enforcement); S.C. Code Ann. § 63-7-920(A)(1) (2010) ("Within twenty-four hours of the receipt of a report of suspected child abuse or neglect or within twenty-four hours after the department has assumed legal custody of a child pursuant to Section 63-7-660 or 63-7-670 or within twenty-four hours after being notified that a child has been taken into emergency protective custody, the department *must* begin an appropriate and *thorough* investigation to determine whether a report of suspected child abuse or neglect is 'indicated' or 'unfounded.'" (emphases added)). In contrast, there is no South Carolina law that authorized Respondent to either (1) retain custody of Child, against his parents' wishes, beyond twenty-four hours,[3] or (2) enter Child's home to investigate his home environment.

---

duty from "standards of care establishing the extent and nature of the duty in a particular case, standards by which a fact finder may judge whether a duty was breached").

[3] Section 63-7-750 of the South Carolina Code (2010) authorizes a treating physician or hospital to detain a child "for up to twenty-four hours without the consent of the person responsible for the child's welfare if the physician or hospital . . . has reason to believe that the child has been abused or neglected."

DSS was actively involved in Child's case as soon as it was notified of the suspicions of Levine's medical team. An on-call caseworker from DSS arrived at Levine on the evening of December 6, 2009, to obtain Child's history and investigate Child's family for possible indicators of an abusive home environment. A DSS caseworker also asked the maternal grandmother and her husband if they would be willing to take custody of Child if DSS determined it was necessary to remove Child from his home. Further, DSS notified the York County Sheriff's Department of the possible abuse of Child, and the Department found no criminal history for Child's mother or father. DSS staff ultimately decided to release Child to his parents and to follow up with a home assessment. Therefore, DSS instructed Respondent to discharge Child to his parents. On December 21, 2009, a DSS caseworker visited Child's home and interviewed Child's mother and father. Notably, DSS did not seek to take Child into emergency protective custody following this visit.

Based on the foregoing, Appellant has not presented any evidence showing that (1) any failure on the part of Levine's staff to exercise reasonable care actually increased the risk of harm to Child, or (2) Child suffered harm because he relied on Respondent's employment of social workers to assess Child. Therefore, Appellant has not established the conditions for liability set forth in section 323 of the Restatement.

In sum, there is no South Carolina precedent for imposing on hospitals a common law duty to protect a juvenile patient from third persons who might inflict harm after he has been discharged from a hospital's care. Further, there is no evidence in this case supporting the conditions for liability set forth in section 323 of the Restatement. Accordingly, we affirm the circuit court's order granting summary judgment to Respondent. In light of the foregoing, we need not reach the merits of Appellant's remaining issue or Respondent's additional sustaining ground. *See Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (holding an appellate court need not address the remaining issues on appeal when resolution of a prior issue is dispositive).

AFFIRMED.

WILLIAMS, GEATHERS, and McDONALD, JJ., concur.

The South Carolina Court of Appeals

Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted], a minor, Appellant.

v.

Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, the York County Sheriff's Department, and York County, Defendants,

Of whom Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center is the Respondent.

Appellate Case No. 2013-002058

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover any material fact or principle of law that has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

_____ J.

_____ J.

_____ J.

Columbia, South Carolina

FILED
10/2/15

cc:
S. Randall Hood, Esquire
Lara Pettiss Harrill, Esquire
Duane Michael Shaw, Esquire
Nathan James Sheldon, Esquire
Jordan Christopher Calloway, Esquire
Monteith Powell Todd, Esquire
Deborah G. Casey, Esquire
Gerald Malloy, Esquire
Robert E. Horner, Esquire
Whitney Boykin Harrison, Esquire
The Honorable S. Jackson Kimball, III

(5)

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

75835

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

RECEIVED
APR 30 2015
SC Court of Appeals

Case No. 2011-CP-46-4508

Elizabeth Hope Rainey, as the
Appointed Guardian ad Litem to
[redacted] a minor ..... Appellant

v.

Charlotte-Mecklenburg Hospital
Authority d/b/a Carolinas Medical
Center; South Carolina Department of
Social Services and Bruce Bryant, as
the Constitutional Office of the Sheriff
of York County, the York County
Sheriff's Department, and York County

Of whom

Charlotte-Meckelnburg Hospital Authority
d/b/a Carolinas Medical Center is..... Respondent.

PETITION FOR REHEARING

Duane M. Shaw
Nathan J. Sheldon
Shaw Law Firm
1169 Ebenezer Road
Rock Hill, SC 29732
(803) 329-4200

S. Randall Hood
Deborah G. Casey
Lara Pettiss Harrill
Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800

Whitney B. Harrison
McGowan, Hood & Felder, LLC
1517 Hampton Street
Columbia, SC 29201
(803) 779-0100

Attorneys for Appellant

Appellant Elizabeth Hope Rainey, as the appointed guardian ad litem to [redacted] petitions the court for rehearing and reconsideration of Unpublished Opinion No. 2015- UP-209 filed April 22, 2015, pursuant to Rule 221(a), SCACR. Appellant asks this court to reconsider the decision to affirm the trial court's finding that no duty existed between the social workers at Charlotte-Mecklenburg Hospital (CMC) and [redacted] Specifically, Appellant seeks review of the mischaracterization of Appellant's arguments because (1) there was a special relationship between CMC and [redacted] and (2) the Record was replete with the necessary evidence of an increased risk of harm and/or actual harm to [redacted] to satisfy the elements of a voluntary undertaking under Restatement (Second) of Torts §323.

I. Pertinent Facts

On December 5, 2009, [redacted] was admitted to CMC's Levine Hospital for injuries he sustained at home under the supervision of his father. R. pp. 411, 448. Tests revealed that [redacted] had a subdural hematoma, i.e. bleeding on the brain. R. pp. 448, 478. Upon admission, CMC initiated internal social work policies. First, CMC contacted the York County division of the South Carolina Department of Social Services (DSS). Second, CMC staff sought consults from CMC's social workers to determine whether [redacted] was being abused or neglected. R. pp. 343-363.

During [redacted]'s hospitalization from December 5-8, 2009, [redacted]'s family was contacted by social workers Katie Harrison and Laura Newmark. R. p. 835; R. p. 873. Medical records reveal that CMC officials were concerned about suspected child abuse and posted a sitter in [redacted]'s hospital room. R. pp. 532, 581. These concerns stemmed from the fact that after the subdural hematoma was diagnosed, [redacted]'s parents could not explain how the injury occurred. R. p. 277.

Once CMC officials have a concern about abuse, internal policies dictate that there be both a medical discharge and social discharge in order for a patient to be cleared to go home. R. p. 343. The night before [redacted] was discharged from CMC, [redacted]'s neurosurgeon found the child was medially cleared for discharge, but made no assessment on his social discharge. Despite evidence suggesting abuse and an incomplete assessment by CMC's social workers, [redacted] was discharged from the hospital to his father, the abuser.

In a matter of weeks, [redacted] was left alone with his abuser. He was hurt again and sustained life altering injuries as a result. When he arrived at CMC for a second time, he was diagnosed with a new subdural hematoma, retinal hemorrhaging, and persistent seizures. R. p. 478. It was determined that [redacted] suffered an anoxic brain injury, causing permanent blindness and deafness.

Before the trial court, Appellant's counsel presented medical records, six inadequate reports generated by CMC's social workers, CMC's policies and procedures for social workers, national standards for social workers, and expert testimony as to the duty CMC and its staff owed [redacted] during his December 2009 hospitalization. *See* Dr. Saverse, R. pp. 34, 209, 239, 529; Kevin Moore, R. p. 529; National Standards, R. p. 251, 269, 294, 352; Juvenile Abuse Policy, R. pp. 341-363. In sum, these materials support that CMC social workers had both a special relationship with [redacted] and that CMC voluntarily undertook to provide social work care to [redacted] in the hospital setting.

II. Special Relationship

The court of appeals mischaracterizes Appellant's argument regarding a special relationship between CMC and [redacted]. First, the court of appeals inadequately distinguishes this case from other supreme courts from around the country where appellate courts have

determined a special relationship exists in these circumstances. Second, the court of appeals incorrectly generalizes Appellant's position in stating, "Appellant is essentially asking this court to impose on all hospitals a common law duty to protect a juvenile patient from third persons who might harm him after he has been discharged from a hospital's care."

South Carolina courts have long recognized that a duty can be based on special circumstances. *Madison v. Babcock Ctr., Inc.*, 371 S.C. 123, 140, 638 S.E.2d 650, 659 (2006); *Jensen v. Anderson County Dep't of Soc. Servs.*, 304 S.C. 195, 199, 403 S.E.2d 615, 617 (1991). Specifically, our courts have explained that a key element in establishing a duty is based on the relationship between the parties. In this case, [redacted] was a three month old child suspected to be a victim of child abuse at the hands of his parents. [redacted] was a patient at CMC. CMC held itself out to be a specialized facility serving both children's medical and social needs. [redacted] was the most vulnerable of patients. He arrived at CMC with two hematomas. His age alone rendered him unable to advocate for himself. CMC and its staff became the only advocate and protector of [redacted]'s medical and social well-being based on its relationship with [redacted]

Other state supreme courts have found that this type of relationship establishes a duty based on these special circumstances. *See Niece v. Elmview Group Home*, 929 P.2d 420, 424 n. 2 (Wash. 1997) ("the relationship between a hospital and its vulnerable patients is a recognized special relationship"); *Henderson v. Gunther*, 931 P.2d 1150, 1155 (Colo. 1997) (en banc) ("special relationships such as . . . a hospital and a patient have been found to impose a duty of care"). The court of appeals suggests that this case is distinguishable from other state appellate courts because Appellant has not challenged the quality of care provided to [redacted] See Unpublished Opinion No. 2015-UP-209 ("However, all of these cases are distinguishable from the present case because Appellant does not challenge the quality of care Respondent provided to

Child during his four-day hospitalization in December 2009."). That is incorrect. The crux of this case is that the quality of care provided by CMC was unacceptable. CMC provided both medical and social care. The care that was provided for [redacted]'s social needs fell well below the standard of care. As written, the court of appeals opinion suggests that the type of services rendered dictate whether or not a special relationship can be formed. This reasoning fails to recognize the interdisciplinary nature of care provided in a hospital setting. CMC offered and inadequately rendered social services as part of the hospital services and treatment. The quality of the social services provided by CMC was deficient and the failure to properly provide those services was negligent.

Further, Appellant is asking this court to rely on *Madison* and *Jensen* to find a special relationship. South Carolina courts have acknowledged that a special relationship can exist and have provided precedent to make such a finding. While the South Carolina Supreme Court has not directly addressed this scenario, it has found that circumstances can create a special relationship and a finding of a duty is appropriate in those instances. Therefore, Appellant respectfully asks this court to reconsider the decision to affirm the trial court.

III. Voluntary Undertaking

The Record provides sufficient evidence to meet the necessary elements of a voluntary undertaking, as outlined by Restatement § 323. Specifically, the evidence demonstrates that (1) CMC's staff failed to exercise reasonable care which increased the risk of harm to [redacted]; and (2) [redacted] suffered harm because he relied on this undertaking. The Restatement only requires that one of these elements be met. Evidence in the Record supports a finding of a voluntary undertaking on either element.

First, if CMC's social workers had properly completed their assessment, as outlined by CMC's policies and procedures and national standards, [redacted] would not have been sent back to his abuser. *See* Dr. Saverse, R. pp. 34, 209, 239, 529; Kevin Moore, R. p. 529; National Standards, R. p. 251, 269, 294, 352; Juvenile Abuse Policy, R. pp. 341-363. For example, CMC's social workers took a minimal psychological assessment. R. pp. 380-386. CMC's social workers failed to explore and probe, and their questioning of [redacted]'s family members lacked the breadth and rigor necessitated in this type of social work case. R. p. 217. If the standard questions had been asked, then a finding of abuse would have been made. For example, if CMC social workers asked the right questions, then they would have discovered: (1) Father acknowledge his relationship with Mother had been strained since [redacted]'s birth; (2) Mother acknowledged that Father had poor parenting skills; (3) the maternal grandmother reported stress between the grandparents and Mother over Father's poor conduct. A proper assessment in December 2009 would have revealed pertinent facts that would have alerted CMC staff that [redacted] was not safe returning to his home. CMC's policies and procedures outline when CMC should retain a child that the staff believes is not safe to return home. R. p. 343. The policy specifically states:

> When a physician determines at a juvenile should remain in the hospital for medical reasons, *or that it is unsafe for the juvenile to return to his or her parent, guardian, or caretaker, the physician or administrator* should first contact the director of [DSS] to determine if [DSS] will take emergency custody and authorize the hospital to retain the physical custody of the juvenile.
>
> In the event [DSS] is unwilling to take custody or cannot be contacted, the local District Court has authorized *the physician or administrator to retain physical custody of the juvenile whenever the physician determines that (1) the juvenile should remain for medical treatment or (2) according to his or her medical evaluations, it is unsafe for the juvenile to return to his parent,*

> *guardian, custodian, or caretaker.* (See Administrative Order, Attachment C).

R. p. 343 (emphasis added).

The risk of harm increased to [redacted] when CMC failed to follow internal policies and procedures, as well as national standards. [redacted] was sent home because pertinent and easily ascertainable information was not uncovered. Had this information been learned, as expected and required by guidelines, the physicians and administrator would have been able to make an educated assessment regarding [redacted]'s safety. An increased risk of harm occurred when CMC's social worker's decided to breach the standard of care.

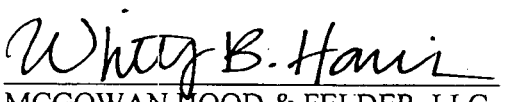
Second, there is no question that [redacted] suffered harm because of this undertaking. While the hematoma he presented with on his second visit to CMC has healed, the lifelong harm [redacted] sustained because he was returned to his abuser will never heal. [redacted] will never walk or see again. He will never exceed the mental capacity of a one year old. [redacted] suffered harm when CMC's social workers were negligent. A social worker exercising the normal standard of care would have seen factor after factor that demonstrated an abusive home and would not have allowed for [redacted]'s return. [redacted] was harmed because CMC didn't fulfill their duty. Evidence in the record establishes that a voluntary undertaking occurred, and therefore, Appellants asks this court to reconsider the finding on the evidence in the record.

CONCLUSION

For the foregoing reasons, Appellant requests this Court to grant this Petition for Rehearing.

Respectfully submitted,

April 30, 2015



MCGOWAN HOOD & FELDER, LLC
Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201
Telephone: (803) 779-0100
Facsimile: (803) 256-0702

MCGOWAN HOOD & FELDER, LLC
S. Randall Hood
Deborah G. Casey
Laura Pettiss Harrill
Jordan C. Calloway
1539 Health Care Drive
Rock Hill, SC 29732
Telephone: (803) 327-7800

SHAW LAW FIRM
Duane M. Shaw
Nathan J. Sheldon
1169 Ebeenezer Road
Rock Hill, SC 29732
Telephone: (803) 329-4200

ATTORNEYS FOR APPELLANTS

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508
Appellate Case No. 2013-002058

Elizabeth Hope Rainey, as the
Appointed Guardian ad Litem to
[redacted] a minor ..... Appellant

v.

RECEIVED
APR 30 2015
SC Court of Appeals

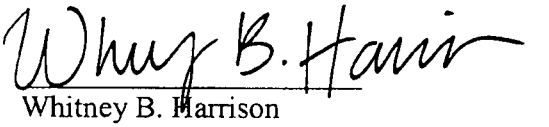
Charlotte-Mecklenburg Hospital
Authority d/b/a Carolinas Medical
Center; South Carolina Department of
Social Services and Bruce Bryant, as
the Constitutional Office of the Sheriff
of York County, the York County
Sheriff's Department, and York County ... Respondents.

PROOF OF SERVICE

The undersigned hereby certifies that on April 30, 2015, she served counsel for Respondent with the *Petition for Rehearing* in this matter by mailing a copy of the same by United States Mail with first class postage prepaid to the following addresses:

Monteith P. Todd, Esquire
Robert E. Horner, Esq.
Sowell, Gray, Stepp & Laffitte, LLC
Post Office Box 11449
Columbia, South Carolina 29211

Patrick J. Frawley, Esquire
David Frawley Law Firm
Post Office Box 489
Lexington, South Carolina 29071



Whitney B. Harrison
McGowan, Hood & Felder, LLC

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
MAY 08 2015
SC Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508
Appellate Case No. 2013-002058

Elizabeth Hope Rainey, as the Appointed
Guardian ad Litem to [redacted], a minor ..... Appellant,

v.

The Charlotte-Mecklenburg Hospital Authority d/b/a
Carolinas Medical Center, South Carolina Department
of Social Services, and Bruce Bryant, as the
Constitutional Office of the Sheriff of York County,
The York County Sheriff's Department, and York County

of Whom

The Charlotte-Mecklenburg Hospital Authority d/b/a
Carolinas Medical Center is ..... Respondent.

RETURN TO PETITION FOR REHEARING

Monteith P. Todd
Robert E. Horner
Sowell Gray Stepp & Laffitte, LLC
1310 Gadsden Street
Post Office Box 11449
Columbia, SC 29211
(803) 929-1400
Attorneys for Respondent

The plaintiff's Petition for Rehearing should be denied because the plaintiff does not raise any new issues or identify any issues overlooked by the Court. Rather, the plaintiff makes the same arguments and cites the same cases this Court has already considered and rejected.

Special Relationship Argument

The plaintiff argues this Court erred in failing to hold that a special relationship existed between the minor child ("Child") and defendant hospital that created a duty of care that extended after the discharge of Child and that the defendant breached this alleged duty. The plaintiff concedes that the defendant did not breach any duty with regard to the medical care provided to Child while he was a patient in the defendant's hospital, but claims the defendant owed a duty to perform a home study or home evaluation before discharging Child. This Court properly rejected this argument because a hospital has no authority to conduct home studies, because the Legislature has placed the sole duty to do such investigations with the South Carolina Department of Social Services, and because neither the South Carolina General Assembly, the South Carolina Supreme Court, nor any other legislature or court anywhere else in the country, has imposed such a duty on a hospital.

Voluntary Undertaking

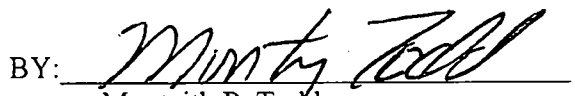
The plaintiff also argues the defendant assumed a duty to act beyond the termination of the hospital-patient relationship, but she cannot point to any evidence of a voluntary undertaking of a duty, any reliance on any voluntary undertaking, or any increase in the risk of the harm as a result of the undertaking. This Court correctly concluded that the defendant complied with its statutory obligations under South Carolina law by notifying DSS of suspected child abuse, and that DSS, upon being notified, had the duty to investigate all of the circumstances surround the Child and his home environment to determine what action should be taken regarding the placement of Child.

After this defendant notified DSS of the suspected abuse, DSS began its investigation, interviewed Child's parents, conducted a home study, and notified the York County Sheriff of the report of suspected abuse. As this Court noted in its Opinion, the plaintiff has not pointed to, nor is there any evidence in the record to show, that any participation or involvement by the hospital's social workers caused DSS or law enforcement to perform a less thorough investigation, that DSS case workers omitted certain tasks from their investigations with an understanding that defendant's social workers had covered or would cover those tasks, or that defendant's social workers caused DSS to determine that Child's discharge to his parents was appropriate when DSS would not have otherwise made that determination. Furthermore, as noted by the Court in its opinion, this defendant had no authority to enter Child's home to investigate his home environment nor did it have authority to retain custody of the child against his parent's wishes, or DSS's directives, once the child was medically cleared for discharge.

Therefore, the plaintiff's Petition for Rehearing should be denied.

Respectfully submitted,

SOWELL GRAY STEPP & LAFFITTE, LLC

BY: 

Monteith P. Todd
Robert E. Horner
1310 Gadsden Street
Post Office Box 11449
Columbia, SC 29211
Tel: 803-929-1400
Fax: 803-231-7887
Email: mtodd@sowellgray.com
Counsel for Defendant/Respondent

Columbia, South Carolina

May 8, 2015

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508
Appellate Case No. 2013-002058

Elizabeth Hope Rainey, as the Appointed
Guardian ad Litem to [redacted], a minor ..... Appellant,

v.

The Charlotte-Mecklenburg Hospital Authority d/b/a
Carolinas Medical Center, South Carolina Department
of Social Services, and Bruce Bryant, as the
Constitutional Office of the Sheriff of York County,
The York County Sheriff's Department, and York County

Of Whom

The Charlotte-Mecklenburg Hospital Authority d/b/a
Carolinas Medical Center is ..... Respondent.

PROOF OF SERVICE

I, the undersigned legal assistant, of the law offices of Sowell Gray Stepp & Laffitte, LLC, attorneys for Respondent, The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, do hereby certify that I have served counsel in this action with a copy of the Return to Petition for Rehearing by mailing a copy of same to counsel via United States Mail, postage prepaid, at the following address(es):

Counsel Served:

S. Randall Hood, Esquire
Deborah G. Casey, Esquire
Lara Pettis Harrell, Esquire
Jordan C. Calloway, Esquire
McGowan Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732

Duane M. Shaw, Esquire
Nathan J. Sheldon, Esquire
Shaw Law Firm
1169 Ebenezer Road
Rock Hill, SC 29732

Whitney B. Harrison, Esquire
McGowan Hood & Felder, LLC
1517 Hampton Street
Columbia, SC 29201

Patrick J. Frawley, Esquire
Davis, Frawley Law firm
Post Office Box 489
Lexington, SC 29071

Robin C. Owens

Robin C. Owens
Legal Assistant

5/8, 2015

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508

Elizabeth Hope Rainey, as the
Appointed Guardian ad Litem to
[redacted] a minor ..... Appellant

v.

Charlotte-Mecklenburg Hospital
Authority d/b/a Carolinas Medical
Center; South Carolina Department of
Social Services and Bruce Bryant, as
the Constitutional Office of the Sheriff
of York County, the York County
Sheriff's Department, and York County

Of whom

Charlotte-Mecklenburg Hospital
Authority d/b/a Carolinas Medical
Center is the ..... Respondent.

RECORD ON APPEAL (VOLUME 1)

Monteith P. Todd
Robert E. Horner
Sowell Gray Stepp & Laffitte, LLC
1310 Gadsden Street
Post Office Box 11449
Columbia, SC 29211
(803) 929-1400

S. Randall Hood
Deborah G. Casey
Lara Pettiss Harrill
Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800

Attorneys for Respondents, The Charlotte Mecklenburg Hospital Authority d/b/a Carolinas Medical Center

Duane M. Shaw
Nathan J. Sheldon
Shaw Law Firm
1169 Ebenezer Road
Rock Hill, SC 29732
(803) 329-4200

Attorneys for Appellant Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted]

January 7, 2014
Rock Hill, South Carolina

INDEX

Order Granting Summary Judgment, dated May 13, 2013 4

Form 4 Order Denying Plaintiff's Motion to Alter or Amend Judgment, dated August 14, 2013 15

Summons and Complaint 17

Answer of Defendant Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center 47

Amended Answer of Defendant Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center 54

Answer of the Defendant South Carolina Department of Social Services 60

Transcript of Record, hearing date April 18, 2013 67

Transcript of Hearing, hearing date August 14, 2013 122

Notice of Motion and Motion for Summary Judgment 173

Memorandum in Support of Motion for Summary Judgment 177

Plaintiff's Memorandum of Law in Opposition to Defendant Charlotte-Mecklenburg Hospital Authority's Motion for Summary Judgment 187

Affidavit of Dr. George W. Savarese, LCSW 209

Exhibit 1—Savarese Curriculum Vitae 243

Exhibit 2—National Association of Social Workers ("NASW") Code of Ethics 2008 251

Exhibit 3—NASW Clinical Social Work in Social Work Practice 2005 269

Exhibit 4—NASW Social Work Practice in Health Care Settings 2005 294

Exhibit 5 –NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital 332

Exhibit 6—CMHA Policy PR 110.03 Juveniles Suspected of Being Abused or Neglected 341

Exhibit 7—Evaluation of Suspected Child Physical Abuse 2007 365

Exhibit 8-23—Medical and DSS Records for [redacted] 380

Exhibit 24—Transcript of Phone Call between York County DSS and the York County Sheriff's Office, dated December 17, 2009 ... 433

Exhibits 25-26—Medical Records for [redacted] (Dec. 2009) Hospitalization 446

Exhibit 27—Excerpt from Deposition of Briggs E. Cook, M.D. 451

Exhibit 28—CMHA Policy PR 110.03, Child Abuse and Neglect Algorithm 453

Exhibits 29-32— Medical Records for [redacted] (Dec. 2009) Hospitalization 455

Exhibit 33—Transcript of Phone Call between York County DSS and the York County Sheriff's Office, dated January 19, 2010 465

Exhibits 34-35—DSS Case Dictation (January-February 2010) 471

Exhibits 36-37—Medical Record for [redacted] (January-February 2010) 476

Exhibit 38—South Carolina DSS Record (January 2010) 480

Exhibit 39—Excerpts from Deposition of Laura Newmark, MSW 482

Exhibit 40—Excerpts from Deposition of Cheryl Courtlandt, M.D. ... 495

Exhibit 41—Excerpts from Deposition of Dirvondra Hill 504

Exhibit 42—Excerpts from Deposition of Krista M. Hinnant 507

Exhibit 43—Excerpts from Deposition of Larry Williams 512

Exhibit 44—Excerpts from Deposition of Charlotte Williams 517

Exhibit 45—Excerpts from Deposition of Kayla Lythgoe 522

Affidavit of J. Kevin Moore 529

Exhibit to Moore Affidavit 535

Plaintiff's Motion for Reconsideration and Memorandum in Support of Motion ... 602

Defendant the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center's Memorandum in Opposition to Plaintiff's Motion for Reconsideration 614

Deposition of Cheryl Courtlandt 619

Deposition of Krista M. Hinnant 661

Deposition of Kayla Lythgoe 776

Deposition of Laura Newmark 833

Deposition of Charlotte Williams 875

Notice of Appeal 916

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF YORK
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2011 CP-46-4508

Elizabeth Hope Rainey, as GAL for [redacted]

PLAINTIFF(S)

The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, et al.

DEFENDANT(S)

Submitted by: Monteith P. Todd	Attorney for : ☐ Plaintiff ☒ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☒ See Page 2 for additional information.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

FILED-RECEIVED
2013 MAY 15 PM 2:24
DAVID HAMILTON
C.C.C.P. & G.S.
YORK COUNTY, S.C.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk : Ends case as to The Charlotte Mecklenburg Hospital Authority d/b/a Carolinas Medical Center Only

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Spec. Circuit Court Judge — Judge Code: 3063 — Date: 5/13/13

For Clerk of Court Office Use Only

This judgment was entered on the 15th day of May, 2013 and a copy mailed first class or placed in the appropriate attorney's box on this 15th day of May 2013 to attorneys of record or to parties (when appearing pro se) as follows:

S. Randall Hood
1539 Health Care Dr.
Rock Hill, SC 29732
ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter:

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

Motion for Summary Judgment on behalf of The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, heard on April 18, 2013 in York County, South Carolina.

STATE OF SOUTH CAROLINA COUNTY OF YORK	)))	IN THE COURT OF COMMON PLEAS
Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted] a minor Plaintiff, v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County, Defendants.	)))))))))))))))))	Case No.: 2011-CP-46-4508 **ORDER FOR SUMMARY JUDGMENT**

FILED-RECEIVED
2013 MAY 15 PM 2:24
DAVID HAMILTON
C.C.C.P.&G.S.
YORK COUNTY, SC

This matter came before me on April 18, 2013, upon the Motion for Summary Judgment of Defendant Charlotte-Mecklenburg Hospital Authority ("CMHA"). Representing Plaintiff was S. Randall Hood, and representing CMHA was Monteith P. Todd. Based on the record presented, I make the following findings and conclusions.

FACTUAL BACKGROUND

This case arises out of physical abuse of a minor child, [redacted] by his father, Michael Carduff. The essential facts of the case are undisputed, and the critical issue presented is whether there was a duty of care imposed on CMHA to refuse to release the child back to his parents after a thorough medical examination was inconclusive of child abuse, and after reporting its findings to the South Carolina Department of Social Services ("DSS"), as required by statute.

On December 4, 2009, [redacted]'s parents brought him to Piedmont Medical Center ("PMC") in Rock Hill for medical attention. On December 5, 2009, the physicians at PMC transferred [redacted] to Levine Children's Hospital ("Levine") at CMHA in Charlotte for further care. The following day, a CT scan by CMHA staff revealed a subdural hematoma, which raised a suspicion of a non-accidental injury to [redacted] At that time, Levine notified DSS of its

mm
#1

suspicion that [redacted] may have been a victim of a non-accidental trauma.

Upon notification of this suspicion, DSS began an investigation into [redacted] and his injuries. While DSS conducted its investigation, the physicians at Levine performed additional tests and studies on [redacted] The results of these tests were essentially normal. Levine advised DSS that it could neither rule in, nor rule out non-accidental trauma as the cause of [redacted]'s injury. They also advised DSS that [redacted] was medically stable, and otherwise ready for discharge. DSS advised Levine that [redacted] should be discharged to his parents, that DSS had entered into a safety plan with [redacted]'s parents, and that DSS would conduct a home investigation. Pursuant to those instructions, Levine discharged [redacted] to his parents on December 8, 2009, having maintained control over [redacted]'s care for four days.

On January 11, 2010, five weeks after discharge, [redacted] was returned to Levine with severe, permanent brain injury caused by abuse by his father. Michael Carduff subsequently pled guilty to abusing [redacted] and causing his catastrophic injuries.

PLEADINGS AND DISCOVERY

Plaintiff commenced this action on December 1, 2011, naming CMHA, DSS and the York County Sheriff's Department as Defendants. Plaintiff alleges that CMHA owed [redacted] a duty not to place him back into an abusive and dangerous environment, and that it breached that duty by discharging [redacted] back to the custody of his parents. Plaintiff further alleges that [redacted] suffered catastrophic injuries as a result of CMHA's negligence. CMHA has denied the allegations of Plaintiff's claims, and asserted certain affirmative defenses, including immunity under S.C. Code Ann. § 63-7-390 (1976, as amended).

The parties subsequently engaged in discovery. By motion dated March 19, 2013, CMHA moved for summary judgment. The basis the motion is twofold: (1) that CMHA did not have, and that Plaintiff could not demonstrate, that CMHA owed [redacted] a duty of care that would prevent the harm complained of; and, (2) that it is granted immunity from liability under S.C. Code Ann. § 63-7-390 (1976, as amended). CMHA and Plaintiff submitted memoranda of law and exhibits in support of their position. After full consideration of the entire record presented, I make the following findings and conclusions.

STANDARD FOR SUMMARY JUDGMENT

Summary judgment is appropriate when it is clear there is no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Baird v. Charleston*

County, 333 S.C. 519, 511 S.E.2d 69 (1999); *Young v. South Carolina Dep't of Corrections*, 333 S.C. 714, 511 S.E.2d 413 (Ct.App.1999); Rule 56(c), SCRCP. In determining whether any triable issue of fact exists, as will preclude summary judgment, the evidence and all inferences which can be reasonably drawn therefrom must be viewed in the light most favorable to the nonmoving party. *Strother v. Lexington County Recreation Comm'n*, 332 S.C. 54, 504 S.E.2d 117 (1998); *Pye v. Aycock*, 325 S.C. 426, 480 S.E.2d 455 (Ct.App. 1997).

In ruling on a summary judgment motion, the Court should consider the pleadings, depositions, interrogatory answers, admissions, and affidavits in determining whether there is a genuine issue of fact for trial, and I have done so. *See Thomas v. Waters*, 315 S.C. 524, 526, 445 S.E.2d 659 (Ct.App. 1994).

Within this framework, summary judgment is appropriate when facts exist on which reasonable minds cannot differ, and it is not appropriate where further inquiry into the facts is desirable to clarify the application of law. It is not, however, sufficient that the nonmoving party seeks to create an inference that is not reasonable, or an issue of fact that is not genuine, in order to avoid summary judgment. *Rothrock v. Copeland*, 305 S.C. 402, 409 S.E.2d 366 (1991).

The purpose of summary judgment is to expedite disposition of cases that do not require the services of a fact finder. In that way, "[a] motion for summary judgment is akin to a motion for a directed verdict" because "[i]n each instance, one party must lose as a matter of law." *George v. Fabri*, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001); Main v. Corley, 281 S.C. 525, 526, 316 S.E.2d 406, 407 (1984); *see, also, Baughman v. American Tel. and Tel. Co.*, 306 S.C. 101, 115, 410 S.E.2d 537, 545 (1991) (standard for summary judgment "mirrors" standard for directed verdict).

"[I]nterpretation of a statute is a question of law for the court." *Catawba Indian Tribe of South Carolina v. State*, 372 S.C. 519, 524, 642 S.E.2d 751, 753 (2007); *Bostic v. American Home Mortgage Servicing, Inc.*, 375 S.C. 143, 147, 650 S.E.2d 479, 481 (Ct.App. 2007). Thus, where there are no issues of fact to be dealt with, summary judgment is the appropriate disposition of the issue.

"The cardinal rule of statutory construction is to ascertain and give effect to the intent of the legislature." *Sloan Constr. Co. v. Southco Grassing, Inc.*, 395 S.C. 164, 170, 717 S.E.2d 603, 606 (2011). "If a statute's language is plain, unambiguous, and conveys a clear meaning, 'the rules of statutory interpretation are not needed and the court has no right to impose another

meaning.'" *Id., quoting Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 582 (2000). When interpreting a statute, the court "must read the language 'in a sense that harmonizes with its subject matter and accords with its general purpose.'" *Ranucci v. Crain*, 397 S.C. 168, 172, 723 S.E.2d 242, 244 (Ct. App. 2012), *quoting Hitachi Data Sys. Corp. v. Leatherman*, 309 S.C. 174, 178, 420 S.E.2d 843, 846 (1992).

It is a question of law for the court to determine the existence of a duty of care, and the scope of that duty. *Oblachinski v. Reynolds*, 391 S.C. 557, 706 S.E.2d 844 (2011); *Madison ex rel. Bryant v. Babcock Center, Inc.*, 370 S.C. 42, 634 S.E.2d 275 (2006); *Staples v. Duell*, 329 S.C. 503, 494 S.E.2d 639 (Ct.App. 1997).

DISCUSSION

1. **Duty of care.**

CMHA moved for summary judgment on the basis that it did not owe a duty to [redacted] to refuse or prevent his discharge back to the custody of his parents. CMHA asserts that once DSS has been notified of the possibility of abuse, and after DSS had ordered the child released to the care of his parents, it had fulfilled its legal responsibility. I agree.

In order to prove negligence, a plaintiff must show: (1) defendant owes a duty of care to the plaintiff; (2) defendant breached the duty by a negligent act or omission; (3) defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) plaintiff suffered an injury or damages. *Steinke v. S.C. Dep't of Labor, Licensing and Regulation*, 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999). If there is no duty, then the defendant in a negligence action is entitled to a directed verdict. *Doe v. Marion*, 373 S.C. 390, 400, 645 S.E.2d 245, 250 (2007), *citing Steinke*, 336 S.C. at 387, 520 S.E.2d at 149.

"A legal duty can be created by statute, a contractual relationship, status, property interest, or some other special circumstance." *Madison ex rel Bryant v. Babcock Center, Inc.*, 371 S.C. 123, 136, 638 S.E.2d 650, 656-57 (2006) (citations omitted.). The determination of the existence of a duty is one of law for the court. *See Doe ex rel Doe v. Wal-mart Stores, Inc.*, 393 S.C. 240, 246, 711 S.E.2d 908, 911 (2011) (a "court must determine, as a matter of law, whether the law recognizes a particular duty"). In this state, ". . . there is no general duty to control the conduct of another or to warn a third person or potential victim of danger . . . ." *Faile v. S.C. Dep't of Juvenile Justice*, 350 S.C. 315, 334, 566 S.E.2d 536, 546 (2002).

The crux of the plaintiff's claim against Charlotte-Mecklenburg Hospital Authority is that

MR #4

Levine had a legal duty not to discharge [redacted] to his parents on December 8, 2009, or a duty to prevent [redacted] from being discharged into the custody of his parents, despite being medically cleared for discharge. Plaintiff asserts that, despite DSS's instruction to discharge [redacted] to his parents, CMHA had a duty to refuse to do so, while CMHA conducted a separate investigation of its own into the possibility of abuse. Plaintiff asserts that if CMHA had done such an investigation, it could have concluded that [redacted] was abused, resulting in [redacted] not being discharged into the custody of his parents. Plaintiff asserts that this would have prevented the catastrophic injury that occurred five weeks later on January 11, 2010.

South Carolina has enacted a comprehensive statutory scheme designed to deal with children suspected child abuse or neglect. Under South Carolina law, DSS, with the assistance of law enforcement and the family court system, is charged with investigating, prosecuting, and adjudicating issues related to the safety of children in their homes, removal from the custody of parents, placement in foster homes, and the ultimate issue of retention of custody for a child's welfare. *See* S.C. Code Ann. § 63-7-10 *et seq.* (1976, as amended). Other than in connection with obvious criminal acts, no other agency of the State has the duty, obligation, or authority to investigate child abuse or neglect cases. Moreover, DSS is the agency given the authority deny or deprive a parent of custody of a child.

Thus, CMHA had no legal right, and no legal duty, to withhold custody of [redacted] from his parents. It fulfilled its statutory duty by properly reporting its findings to DSS.

By statute, certain persons are required to report suspected child abuse or neglect. Physicians, nurses, healthcare professionals, and other designated people are required to report suspected child abuse or neglect to the county DSS, or to a law enforcement agency in the county where the child resides. *See* S.C. Code Ann. § 63-7-310. This section states, in relevant part:

> A physician, nurse, . . . or any other ... health professional . . . **must report** in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected as defined in Section 63-7-20.
>
> * * * * *
>
> (D) Reports of child abuse or neglect may be made orally by telephone or otherwise to the county department of social services or to a law enforcement agency in the county where the child resides or is found. (Emphasis added.)

It is uncontested that Levine complied with this statutory requirement by reporting to DSS that [redacted] may have been a victim of non-accidental trauma. Once this report was made, the DSS became responsible for implementing the child welfare process for [redacted]'s protection, including any decision to withhold custody from the parents. *See* S.C. Code Ann. § 63–7–660 (DSS may remove a child from his or her home and has legal custody of the child thereafter if there is probable cause to believe abuse or neglect has occurred); *see also South Carolina Dept. of Social Services v. Randy S.*, 390 S.C. 100, 700 S.E.2d 250 (Ct. App. 2010) (noting that Section 63–7–1660(A) grants to DSS alone the authority to petition the family court to remove a child from custody of a parent if DSS "determines by a preponderance of evidence that the child is an abused or neglected child"); *South Carolina Department of Social Services v. Pritchard*, 329 S.C. 242, 246, 495 S.E.2d 242, 244 (Ct. App. 1997) (same); *Doe v. Marion*, 373 S.C. 390, 645 S.E.2d 245 (same).

There is no statutory or common law authority in South Carolina that would grant CMHA the authority to remove a child from the custody of his parents, or to refuse discharge of a child to his parents when the child is medically ready for discharge. The reporting statute does not enhance the duty of a reporting entity to require it to prevent a child from being returned to its parents after DSS has instructed that the child should be returned. In *Doe v. Marion, supra*, the Supreme Court held that even the failure to report under the statute does not create a private right of action. On the other hand, had CMA attempted to retain this child in its custody absent a court order or directive from DSS, it would have been potentially liable for false imprisonment or kidnapping.

Plaintiff also argues that Levine had a statutory duty and right to refuse to discharge Owen to his parents under S.C. Code Ann. § 63-7-750, which reads as follows:

> § 63-7-750. Doctor or hospital may detain child; civil immunity.
>
> (A) A physician or hospital to which a child has been brought for treatment <u>may</u> detain the child for up to twenty-four hours without the consent of the person responsible for the child's welfare if the physician or hospital:
>
> (1) has reason to believe that the child has been abused or neglected;
>
> (2) has made a report to a law enforcement agency and the department pursuant to Section 63-7-310, stating the time the physician notified the agency or department that the child was being detained until a law enforcement officer could arrive to determine whether the officer should take emergency physical

ONE
#6

> custody of the child pursuant to Subarticle 3; and
>
> (3) has reason to believe that release of the child to the child's parent, guardian, custodian, or caretaker presents an imminent danger to the child's life, health, or physical safety. A hospital must designate a qualified person or persons within the hospital who shall have sole authority to detain a child on behalf of the hospital.
>
> (B) A physician or hospital that detains a child in good faith as provided in this section is immune from civil or criminal liability for detaining the child. (Emphasis added.)

I disagree with Plaintiff's construction. I find and conclude that the ability to retain a child under this section is limited to a twenty-four hour period to afford the hospital opportunity to contact law enforcement or DSS in order that such agency may investigate the hospital's concern. This was accomplished, and DSS had already directed that [redacted] be discharged to his parents. In any event, CMHA retained [redacted] well beyond the authorized twenty-four hours in the course of its own further investigation of its concern of child abuse. Further, and in any event, the right to retain the child is permissive and not mandatory. *See* § 63-7-750(A).

In summary, I find and conclude that the entity obligated to retain custody over a child in derogation of a parent's rights is DSS, or temporarily, a law enforcement agency, and then only if these entities meet the statutory requirements to do so. In this case, [redacted] remained in Levine from December 5 until December 8, 2009. Levine notified DSS of the possibility of abuse on December 6, 2009, and DSS began investigating the matter that same day. Under the statute, any authority the hospital had to retain the child for up to twenty-four expired, and the decision as to whom [redacted] would be discharged belonged to DSS, not CMHA.

Notwithstanding these findings and conclusions, Plaintiff attempts to create a duty by expanding the scope of CMHA's duty through the submission of an expert's affidavit which asserts that Levine "abrogated a duty or responsibility to [redacted]." The expert's opinions are based on this expert's interpretation of hospital accreditation standards and internal hospital policies. I find and conclude that these expert opinions do not create a duty at law, or expand the statutory scheme promulgated by the legislature.

The existence of a duty is a legal question for determination by the court. Because the determination of the existence of a duty is a legal question, the plaintiff cannot create a duty through expert testimony or internal policies and procedures, where the duty does not otherwise exist at law. *Trotter v. State Farm Mut. Auto. Ins. Co.*, 297 S.C. 465, 480, 377 S.E.2d 343, 351

(1988) (opinion testimony cannot create a duty that does not exist at law); *see also, Citizens and Southern National Bank of South Carolina v. Lanford*, 313 S.C. 540, 443 S.E.2d 549 (1994)

Further, Plaintiff's effort to create a common law duty, or a duty that reaches beyond the plain language of the statutes at issue, ignores basic rules of statutory construction. The court ". . . must presume that the legislature did not intend a futile act, but rather intended its statutes to accomplish something." *Denene, Inc. v. City of Charleston*, 352 S.C. 208, 212, 574 S.E.2d 196, 198 (2003) (*citing TNS Mills, Inc. v. S.C. Dep't of Revenue*, 331 S.C. 611, 503 S.E.2d 471 (1998). If a common law duty to report and prevent child abuse existed without the need for §§ 63-7-310 and 63-7-750, the action of the General Assembly in promulgating these statutes would have been unnecessary. These statutes create a duty where there was none at common law, and the duty created is more narrow than that asserted by Plaintiff.

I find and conclude that there is no duty or obligation for a hospital to refuse to discharge a child, who is medically stable, when DSS has directed that the child be discharged to the parents. The applicable statutes in this case provide only a limited right to retain the child in derogation of a parents' custodial rights. This limited right permits such retention for only twenty-four hours, and only in order that law enforcement or DSS can be contacted and conduct an investigation.

Thus, I find and conclude that CMHA had neither the right, nor the duty to refuse discharge of [redacted] to his parents under the circumstances. CMHA met its duties in this case by reporting its suspicion of a non-accidental trauma to DSS. Further, it fulfilled its legal duty in returning [redacted] to the custody of his parents upon being advised by DSS to do so. The decision as to whether [redacted] should be discharged to his parents was a decision for DSS, not for CMHA.

2. **<u>Immunity regarding reporting of abuse</u>.**

CMHA also argued statutory immunity from liability pursuant to S.C. Code Ann. § 63-7-390, which provides:

> A person required or permitted to report pursuant to Section 63-7-310 or who participates in an investigation or judicial proceedings resulting from the report, acting in good faith, is immune from civil and criminal liability which might otherwise result by reason of these actions. In all such civil or criminal proceedings, good faith is rebuttably presumed. Immunity under this action extends to full disclosure by the person of facts which gave the person reason to believe that the child's physical or mental health or

> welfare had been or might be adversely affected by abuse or neglect.

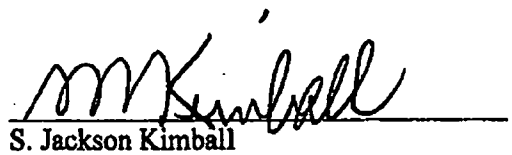
Plaintiff's claim in this case is not premised on the fact that CMHA reported its suspicion of abuse. No issue is raised concerning the fact that Levine reported [redacted]'s condition to DSS, as required by 63-7-310. Rather, Plaintiff's claim is premised on the assertion of a further duty to retain custody of [redacted], and to refuse to return him to his parents' custody. Thus, § 63-7-390 has no application to the facts of this case, and I so find and conclude.

CONCLUSION

Therefore, based on the discussion herein, the motion for summary judgment of the Defendant Charlotte-Mecklenburg Hospital Authority is granted.

AND IT IS SO ORDERED.

May 13, 2013



S. Jackson Kimball
Special Circuit Court Judge
York County

#9

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF YORK
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP4604508

PLAINTIFF(S)	DEFENDANT(S)
Elizabeth Hope Rainey [redacted]	Charlotte Mecklenburg Hospital Authority Department of Social Services South Carolina York County Sheriffs Department Carolinas Medical Center Bruce Bryant York County

Submitted by:

Attorney for: ☐ Plaintiff ☐ Defendant ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED (*CHECK REASON*):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____

☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):** ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other:

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order; (formal order to follow) ☐ Statement of Judgment by the Court:

This matter came before me on August 14, 2013, upon Plaintiff's motion pursuant to Rule 59(e), SCRCP, asking the Court to alter or amend the Court's Order filed May 15, 2013. Representing the parties were: Deborah Casey for Plaintiff, Monteith Todd for Defendant Charlotte-Mecklenberg Hospital Authority, and Patrick Frawlely for Defendant S.C. Dept. of Social Services.

Upon reviewing the record presented, and considering the memoranda and arguments of counsel, I find no matter presented that was not addressed expressly or by clear implication in the prior order. I further find no basis for reconsideration or amendment of the court's ruling in the prior order. Plaintiff's case is tragic, but Plaintiff's position asks the court to make inferences, suppositions, and conclusions that are not supported by the extensive discovery in this case, and, in my judgment, go beyond the scope of existing precedent on the issues presented.

Therefore, it is ordered that Plaintiff's Motion pursuant to Rule 59(e), SCRCP, be denied.

AND IT IS SO ORDERED.

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.

Additional Information for the Clerk: _____

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**

Special Circuit Court Judge	3063 Judge Code	8/14/2013 Date

For Clerk of Court Office Use Only

This judgment was entered on , and a copy mailed first class or placed in the appropriate attorney's box on , to attorneys of record or to parties (when appearing pro se) as follows:

S. Randall Hood and Deborah Casey 1539 Health Care Dr. Rock Hill, SC 29732
Duane Michael Shaw PO Box 36250 Rock Hill, SC 29732

ATTORNEY(S) FOR THE PLAINTIFF(S)

Patrick John Frawley PO Box 489 Lexington, SC 290710489
Monteith Powell Todd PO Box 11449 Columbia, SC 29211
Janet Brooks Holmes PO Box 7217 Columbia, SC 29202

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter: Susan Wyatt

David Hamilton - Clerk of Court

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

_____

_____

_____

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

#2

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)
)

IN THE COURT OF COMMON PLEAS

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to [redacted] a minor, **Plaintiff(s)**)
)
vs.)
)
Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sherriff of York County, The York County Sheriff's Department, and York County **Defendant(s)**)

CIVIL ACTION COVERSHEET

11-CP - 46- 04508

FILED-RECEIVED
2011 DEC -1 AM 9:42
DAVID HAMILTON
C.C.C.P.&G.S.
YORK COUNTY, SC

(Please Print)
Submitted By: S. Randall Hood
Address: 1539 Health Care Drive, Rock Hill, SC 29732

SC Bar #: 65360
Telephone #: 803-327-7800
Fax #: 803-328-5656
Other:
E-mail: rhood@mcgowanhood.com

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (*Check all that apply*)

If Action is Judgment/Settlement do not complete

☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to **ARBITRATION** pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is subject to **MEDIATION** pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (*Check One Box Below*)

Contracts
- ☐ Constructions (100)
- ☐ Debt Collection (110)
- ☐ Employment (120)
- ☐ General (130)
- ☐ Breach of Contract (140)
- ☐ Other (199)

Torts - Professional Malpractice
- ☐ Dental Malpractice (200)
- ☐ Legal Malpractice (210)
- ☐ Medical Malpractice (220)

Previous Notice of Intent Case # 20____-CP-_____-_____
- ☐ Notice/ File Med Mal (230)
- ☐ Other (299)

Torts – Personal Injury
- ☐ Assault/Slander/Libel (300)
- ☐ Conversion (310)
- ☐ Motor Vehicle Accident (320)
- ☐ Premises Liability (330)
- ☐ Products Liability (340)
- ☒ Personal Injury (350)
- ☐ Wrongful Death (360)
- ☐ Other (399)

Real Property
- ☐ Claim & Delivery (400)
- ☐ Condemnation (410)
- ☐ Foreclosure (420)
- ☐ Mechanic's Lien (430)
- ☐ Partition (440)
- ☐ Possession (450)
- ☐ Building Code Violation (460)
- ☐ Other (499)

Inmate Petitions
- ☐ PCR (500)
- ☐ Mandamus (520)
- ☐ Habeas Corpus (530)
- ☐ Other (599)

Judgments/Settlements
- ☐ Death Settlement (700)
- ☐ Foreign Judgment (710)
- ☐ Magistrate's Judgment (720)
- ☐ Minor Settlement (730)
- ☐ Transcript Judgment (740)
- ☐ Lis Pendens (750)
- ☐ Transfer of Structured Settlement Payment Rights Application (760)
- ☐ Other (799)

Administrative Law/Relief
- ☐ Reinstate Driver's License (800)
- ☐ Judicial Review (810)
- ☐ Relief (820)
- ☐ Permanent Injunction (830)
- ☐ Forfeiture-Petition (840)
- ☐ Forfeiture—Consent Order (850)
- ☐ Other (899)

Appeals
- ☐ Arbitration (900)
- ☐ Magistrate-Civil (910)
- ☐ Magistrate-Criminal (920)
- ☐ Municipal (930)
- ☐ Probate Court (940)
- ☐ SCDOT (950)
- ☐ Worker's Comp (960)
- ☐ Zoning Board (970)
- ☐ Public Service Commission (990)
- ☐ Employment Security Comm (991)
- ☐ Other (999)

Special/Complex /Other
- ☐ Environmental (600)
- ☐ Automobile Arb. (610)
- ☐ Medical (620)
- ☐ Other (699)
- ☐ Pharmaceuticals (630)
- ☐ Unfair Trade Practices (640)
- ☐ Out-of State Depositions (650)
- ☐ Motion to Quash Subpoena in an Out-of-County Action (660)
- ☐ Sexual Predator (510)

Submitting Party Signature: _____ **Date:** 11/30/11

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

FOR MANDATED ADR COUNTIES ONLY

Allendale, Anderson, Beaufort, Clarendon, Colleton, Florence, Greenville, Hampton, Horry, Jasper, Lee, Lexington, Pickens (Family Court Only), Richland, Sumter, Union, Williamsburg, and York

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.

2. The initial ADR conference must be held within 300 days after the filing of the action.

3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)

4. Cases are exempt from ADR only upon the following grounds:

   a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;

   b. Requests for temporary relief;

   c. Appeals

   d. Post Conviction relief matters;

   e. Contempt of Court proceedings;

   f. Forfeiture proceedings brought by governmental entities;

   g. Mortgage foreclosures; and

   h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.

5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.

6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: **You must comply with the Supreme Court Rules regarding ADR. Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMMON PLEAS**
	)	
COUNTY OF YORK	)	**SIXTEENTH JUDICIAL CIRCUIT**
Elizabeth Hope Rainey, as the appointed Guardian Ad Litem to [redacted] a minor,	)	**C.A. Number: 11-CP-46-04608**
Plaintiff	)	**SUMMONS (Jury Trial Demanded)**
v.	)	
Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County	)	
Defendants	)	

FILED-RECEIVED
2011 DEC -1 AM 9:42
DAVID HAMILTON
C.C.C.P. & G.S.
YORK COUNTY, SC

TO: THE DEFENDANTS IN THE ABOVE NAMED ACTION

YOU ARE HEREBY SUMMONED and required to Answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said Complaint on the subscriber at his Office at 1539 Healthcare Drive, Rock Hill, South Carolina, 29732, within thirty (30) days from the service hereof, exclusive of the date of such service; and if you fail to Answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.

[SIGNATURE PAGE TO FOLLOW]

S. Randall Hood
Jordan Calloway
Lara Pettis Harrill
MCGOWAN, HOOD, & FELDER, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732
(803) 327-7800
(803) 328-5656 (Fax)
rhood@mcgowanhood.com
jcalloway@mcgowanhood.com
lharrill@mcgowanhood.com

Duane M. Shaw
Nathan J. Sheldon
SHAW LAW FIRM
1169 Ebenezer Road
Rock Hill, South Carolina 29732
(803) 329-4200
(803) 329-4202 (Fax)
shaw@shawlawfirm.net
sheldon@shawlawfirm.net

Rock Hill, South Carolina

November 30, 2011

STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMMON PLEAS**
	)	
COUNTY OF YORK	)	**SIXTEENTH JUDICIAL CIRCUIT**
Elizabeth Hope Rainey, as the appointed Guardian Ad Litem to [redacted] a minor,	)	**C.A. Number: 11-CP-46-** 04508
Plaintiff	)	**COMPLAINT**
v.	)	**(Jury Trial Demanded)**
Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County	)	
Defendants	)	

FILED-RECEIVED
2011 DEC -1 AM 9:42
DAVID HAMILTON
C.C.C.P. & G.S.
YORK COUNTY, SC

Plaintiff, by and through her undersigned counsel, for a Complaint against the Defendants, respectfully alleges as follows:

PARTIES

Plaintiffs

1. Plaintiff Elizabeth Hope Rainey, ("Rainey") is a citizen and resident of York County, South Carolina and is the duly appointed guardian ad litem of the minor child, [redacted]. She brings this action on behalf of the Minor catastrophically injured by Defendants' actions.

Defendants

2. Upon information and belief, Charlotte Mecklenburg Hospital Authority doing

business as Carolinas Medical Center, ("CMC") is a North Carolina corporation, with its principal place of business in Mecklenburg County, North Carolina where it does business as Carolinas Medical Center and operates a hospital in Mecklenburg County known as Carolinas Medical Center

3. Upon information and belief, Defendant South Carolina Department of Social Services ("SCDSS") is a governmental entity that has its principal place of business in Richland County, South Carolina. In the case at hand, SCDSS employed persons and had agents working out of its York County office who failed to perform as a reasonably prudent social worker which resulted in damages and injuries to [redacted] SCDSS is sued pursuant to the South Carolina Tort Claims Act which makes the employing entity liable for the torts of its employees (S.C. Code Ann. §15-78-70) and pursuant to the South Carolina Children's Code (S.C. Code Ann. § 63-1-10 et. seq.). Plaintiff alleges all employees of SCDSS were acting within the course and scope of their official duties in relation to this claim.

4. Defendant Bruce Bryant ("Sheriff"), at all relevant times, was York County Sheriff and had responsibility for the management and operation of employees and agents of the York County Sheriff's Department. He is sued in his representative capacity for the office of the York County Sheriff's Department pursuant to the South Carolina Tort Claims Act that makes the employing entity liable for the torts of its employees (S.C. Code Ann. §15-78-70). Plaintiff alleges the York County Sheriff's Office is liable for the acts and omissions of certain employees that resulted in injuries and damages to [redacted] Plaintiff alleges all employees of the York County Sheriff's department were acting within the course and scope of their official duties in relation to this claim. Sheriff Bryant is sued for compensatory damages under state law.

5. Defendant York County ("YC") is a governmental entity with its principal place of business located in York County, South Carolina. Many of the employees of SCDSS and York County Sheriff's Department may have been receiving paychecks from YC in this case, though they are alleged to work for another governmental entity and/or agency. Upon information and belief, if the employee was paid monetary compensation by YC, then YC had the ability to control, maintain or supervise the employee and Plaintiff is alleging that SCDSS and York County Sheriff's Department employees were negligent in regard to [redacted], which resulted in his injuries and damages.

6. Upon information and belief, all Defendants had the right and/or power to direct and control the manner in which its employees and/or agents provided social worker or law enforcement care to [redacted] in December 2009 and January 2010.

7. Upon information and belief, the negligent acts, omissions and liability of all Defendants includes their agents, principals, employees and/or servants, both directly and vicariously, pursuant to principals of non-delegable duty, corporate liability, apparent authority, agency, ostensible agency and/or respondeat superior.

JOINT AND SEVERAL LIABILITY

8. Defendants are jointly and severally liable for all damages alleged since their negligent, grossly negligent, reckless and wanton acts and omissions, singularly or in combination, are the direct and proximate cause of the minor Plaintiff's damages, injuries and losses.

GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS

9. The minor Plaintiff ([redacted]) was born on September 9, 2009 to his parents

Kayla Lythgoe and Michael Carduff.

10. Owen was transported by his mother and father to Piedmont Medical Center on December 4, 2009, allegedly because he was listless and lethargic.

11. The medical staff and nurses at Piedmont Medical Center examined Owen on December 4, 2009 and decided to transfer him to CMC in Charlotte, North Carolina.

12. When [redacted] arrived at CMC on December 4, 2009, he was taken to the emergency room at the hospital for children and which is known as Levine Children's Hospital.

13. Upon information and belief, around the time [redacted] was seen at Levine Children's Hospital, staff and/or nurses began to suspect the minor child was the victim of child abuse or "non-accidental trauma" ("NAT").

14. [redacted] was then transferred to a room at CMC and the minor began to have a work up for NAT.

15. The child had been reported to have only been in his mother or father's care and they were the only persons who could have perpetrated child abuse upon this helpless 11 week old child.

16. Upon information and belief, Charlotte, North Carolina is a large metropolitan area and CMC is the hospital where the majority of child abuse victims are sent in this region. The employees and agents of CMC should be well versed in ways to protect a child from further abuse.

17. [redacted] was treated over the next few days and began to recuperate and recover from the injuries suffered at the hands of his father, Michael Carduff.

18. Michael Carduff and Kayla Lythgoe were with [redacted] while in Charlotte

but by virtue of the history of the parents, one of the two of them was the only possible source of [redacted]'s NAT.

19. [redacted] continued to receive treatment for his NAT injuries at CMC and was then examined by a pediatric neurosurgeon who decided to discharge the child from CMC as long as the social worker employees and agents of CMC promulgated their due diligence with regard to [redacted] and ensured that [redacted] was discharged back to a safe environment.

20. Prior to discharge, the social worker at CMC responsible for the discharge had a duty and responsibility to [redacted] to ensure he was not discharged back into the environment from which he had suffered grievous injury.

21. There were multiple ways to ensure the child would have been discharged in a safe manner but CMC employees failed him in every way and allowed this minor child to be discharged into the hands of the man who had put him in the hospital, Michael Carduff.

22. The social worker from CMC, upon information and belief, contacted the York County Division of SCDSS and advised that some person in the York County office needed to follow up with the family.

23. SCDSS was aware that the child had been discharged back into the care and custody of potential child abusers, but failed to do an appropriate follow up to ensure the child was safe.

24. Some time in the middle of December 2009, the York County Sheriff's Department was faxed a notice to do an investigation of Michael Carduff to ascertain how [redacted] suffered severe and serious injuries in the first place.

25. It does not appear that the CMC social worker, any employee or social worker

from the York County Division of the SCDSS or any member of the York County Sheriff's Department did anything to ensure [redacted]s safety from December 8, 2009 until January 11, 2010.

26. On January 11, 2010, it appears [redacted] was beat mercilessly and put into a coma by the person who caused his first hospitalization in December 2009, Michael Carduff.

27. Owen was once again first taken to Piedmont Medical Center in Rock Hill, South Carolina on January 11, 2010 and then transferred by emergency vehicle to CMC on January 11, 2010.

28. The child was in serious danger of death on January 11, 2010 but he did not die.

29. The child was in a coma and had suffered serious and disabling brain damage that caused extreme cognitive difficulties and blindness.

30. If any of the Defendants had not breached a duty to [redacted] in December 2009 after his discharge from CMC until he was beat mercilessly again on January 11, 2010, he would not have suffered life altering and catastrophic injuries.

31. But for the actions and inactions of the employees and agents of the Defendants, [redacted] would be a happy, healthy child today.

FOR A FIRST CAUSE OF ACTION
(Negligence - CMC)

32. Plaintiff reallages and reiterate paragraphs 1 through 31, as though fully set forth herein verbatim, and further allege:

33. While [redacted] was at CMC in December 2009, he was under the care of CMC employees and/or agents.

34. Upon information and belief, when Owen was discharged on December 8, 2009, he should have not been placed back into the custody of the people who had harmed him and employees and agents of CMC should have ensured they did not discharge [redacted] back to the person who hurt him in the first place, Michael Carduff.

35. CMC agents and employees had a duty to [redacted] not to place him back into an abusive and terribly dangerous environment and breached that duty to [redacted] and were thereby negligent, careless, grossly negligent, reckless and acted in violation of the duties owed to decedent in that they committed one or more of the following acts of omission or commission, any or all of which were departures from the duty owed to the minor Plaintiff:

a. in failing to adequately consider or determine whether [redacted] could be safely discharged into the care of his parents Kayla Lythgoe and Michael Carduff on December 8, 2009;

b. in failing to adequately recognize or adequately consider the fact that [redacted] had been injured by one of his parents and that a social worker from CMC was discharging back to his likely abuser(s);

c. in failing to implement, or cause to be implemented, adequate additional assessment of the minor Plaintiff's discharge to ensure he was placed back into a safe environment;

d. in failing to reasonably determine whether [redacted]'s parents were qualified to assume his care;

e. in failing to provide or arrange, or reasonably attempting or arrange, another safe and appropriate manner to discharge [redacted] to ensure his safety from a likely abuser;

f. in failing to adequately communicate the condition and safety needs of [redacted] to the appropriate staff at the York County Division of SCDSS;

g. in failing to properly train and educate their employees in the proper manner to discharge a child who the victim of suspected child abuse;

h. in failing to have proper policies and procedures in place regarding discharge of

victims of suspected child abuse to the hands of their suspected abuser; and,

i. in such other particulars as may be ascertained through discovery procedures undertaken pursuant to the South Carolina Rules of Civil Procedure.

36. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the standards of care by Defendants, the Minor Plaintiff suffered severe debilitating injuries which resulted in brain damage, blindness and catastrophic injuries, for which Plaintiff is entitled to recover on behalf of the minor Plaintiff actual damages and punitive damages in an amount to be determined by a jury at the trial of this action.

FOR A SECOND CAUSE OF ACTION
(Negligence - SCDSS and YC)

37. Plaintiff reiterates and realleges paragraphs 1 through 36 as though set forth herein verbatim, and further alleges:

38. When [redacted] was discharged from CMC on December 8, 2009, SCDSS was notified at some later time that he was a potential victim of child abuse.

39. SCDSS employees and agents had a duty to properly investigate and ensure that [redacted] was safe after SCDSS was notified of a potential harm to [redacted] in December 2009.

40. Since the potential victim of the child abuse in this case was a few weeks old, he was helpless to assist himself. SCDSS and YC employees and Agents were aware in December 2009 that [redacted] was a potential victim of child abuse by a parent. Upon information and belief, they were aware that one of his parents had caused injuries and damages sufficient to put the minor child in the hospital for five days. They were aware, amazingly, he was discharged

back into the home of the suspected abuser.

41. SCDSS and YC did nothing to protect the child.

42. YC paid some of the people involved in the supposed follow up investigation of Michael Carduff in December 2009 and January 2010. If the person who perpetrated negligent acts in regard to [redacted] was employed by SCDSS or York County Sheriff's department but was receiving payment by YC, upon information and belief, they would have been employed in part by YC and YC would be responsible for the acts or omissions of such person causing injuries and damages to [redacted]

43. Since SCDSS, York County Sheriff's Department and YC received a report of suspected child abuse and since [redacted] was a helpless infant, SCDSS and YC had a special relationship with [redacted] and owed a duty to Owen Carduff.

44. SCDSS, York County Sheriff's Department and YC voluntarily undertook an investigation of suspected abuse of [redacted] and therefore owed [redacted] a duty of reasonable care to gather facts sufficient to enable SCDSS, York County Sheriff's Department and YC to determine whether claim of suspected abuse was indicated or unfounded.

45. The South Carolina Children's Code (S.C. Code Ann. § 63-7-920) imposed a duty on SCDSS, York County Sheriff's Department and YC to conduct an "appropriate and thorough investigation" of claims that [redacted] was abused.

46. SCDSS, York County Sheriff's Department and YC agents and employees breached their duties to [redacted] and were thereby negligent, careless, grossly negligent, reckless and acted in violation of their duties in that they committed one or more of the following acts of omission or commission, any or all of which were departures from the duty owed to the

minor Plaintiff:

a. in failing to adequately consider or determine whether [redacted] could be safely discharged into the care of his parents Kayla Lythgoe and Michael Carduff;

b. in failing to adequately recognize or adequately consider the fact that [redacted] had been injured by one of his parents and that a social worker from CMC was discharging [redacted] back to his likely abuser(s);

c. in failing to implement, or cause to be implemented, adequate additional assessment of the minor Plaintiff's discharge to ensure he was placed in a safe environment;

d. in failing to reasonably determine whether or not the parents of [redacted] were qualified to assume the minor Plaintiff's care;

e. in failing to provide or arrange, or reasonably attempting or arrange, another safe and appropriate manner to discharge [redacted] to ensure his safety from a likely abuser;

f. in failing to adequately investigate and determine whether it was safe for [redacted] to be in the care and custody of Michael Carduff;

g. in failing to properly train and educate their employees in the proper manner to ensure a safe placement and discharge of a child who is the suspected victim of child abuse;

h. in failing to have proper policies and procedures in place in regard to the discharge, placement, investigation, removal and protection of victims of suspected child abuse, especially when the employees or agents are aware of the placement of the child back into the hands of a suspected abuser;

i. in failing to ensure that the Sheriff or one of his employees had conducted a proper investigation into the injuries of [redacted] and ensured the minor Plaintiff was not at risk of further injury at the hands of one of his parents, and specifically, Michael Carduff;

j. In negligently per se failing to comply with the children's code in multiple ways, and,

k. in such other particulars as may be ascertained through discovery procedures undertaken pursuant to The South Carolina Rules of Civil Procedure.

47. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the standards of care by SCDSS and YC, the minor Plaintiff suffered from severe injuries which resulted in brain damage, blindness and catastrophic damages, for which the Plaintiff is entitled to recover on behalf of the minor Plaintiff actual damages and punitive damages in an amount to be determined by a jury at the trial of this action.

FOR A THIRD CAUSE OF ACTION
(Negligence - Sheriff Bryant, York County Sheriff's Department and YC)

48. Plaintiff reiterates and realleges paragraphs 1 through 47 as though set forth herein verbatim, and further alleges:

49. When [redacted] was discharged from CMC on December 8, 2009, the SCDSS was notified at some later time that [redacted] was a potential victim of Child abuse.

50. SCDSS employees and agents, upon information and belief, notified the York County Sheriff's Department of a potential situation involving the child abuse of [redacted]

51. Upon information and belief, the York County Sheriff's Department attempted on one occasion to ride by the house of Plaintiff's parents but failed to perform any modicum of investigation to determine whether [redacted] was a potential victim of child abuse.

52. Since the potential victim of child abuse in this case was a few weeks old, he was helpless to assist himself. Employees and agents of Sheriff Bryant and York County Sheriff's Department were aware in December 2009 that [redacted] was a potential victim of child abuse by a parent. They were aware that he was living with his parents. Upon information and belief, they were aware that, potentially, one of his parents had caused injuries and damages sufficient to put the minor child in the hospital for five days. They were aware, amazingly, he

was discharged back into the home of the suspected abuser.

53. Sheriff Bryant and York County Sheriff's Department employees and agents did nothing to protect the child.

54. YC paid some of the people involved in the supposed follow up investigation of Michael Carduff in December 2009 and January 2010. If the person who perpetrated negligent acts in regard to [redacted] was employed by SCDSS or York County Sheriff's Department but was receiving payment by YC, upon information and belief, they would have been employed in part by YC and YC would be responsible for the acts or omissions of such person which caused injuries and damages to the minor Plaintiff, [redacted]

55. Sheriff Bryant and York County Sheriff's Department employees and agents had a special relationship to the victim, and voluntarily undertook a duty to investigate the cause of the [redacted]'s injuries. The Children's Code imposes a duty on Sheriff Bryant and York County Sheriff's Department employees and agents to [redacted] By virtue of all of these special relationships and circumstances, Sheriff Bryant and York County Sheriff's Department agents and employees had a duty to [redacted]

56. Agents and employees of Bryant (through York County Sheriff's Department) breached that duty to [redacted] and were thereby negligent, careless, grossly negligent, reckless and acted in violation of the duties in that they committed one or more of the following acts of omission or commission, any or all of which were departures from the duty:

a. in failing to adequately investigate claims of child abuse against [redacted] to consider or determine whether or not [redacted] could be safely protected from his parents Kayla Lythgoe and Michael Carduff;

b. in failing to adequately investigate and/or recognize or adequately consider the fact that [redacted] had been injured by one of his parents;

c. in failing to implement, or cause to be implemented, adequate additional investigation of the minor Plaintiff's ability to safely reside in his parent's home or reside in a safe environment;

d. in failing to reasonably determine whether or not the parents of [redacted] were harming [redacted]

e. in failing to take [redacted] into protective custody;

f. in failing to adequately investigate and determine whether it was safe for [redacted] to be in the care and custody of Michael Carduff;

g. in failing to properly train and educate their employees in the proper manner to ensure a safe placement and discharge of a child who is the suspected victim of child abuse;

h. in failing to have proper policies and procedures in place in regard to the discharge, placement, investigation, removal and protection of victims of suspected child abuse, especially when the employees or agents are aware of the placement of the child back into the hands of a suspected abuser;

i. In negligently per se failing to comply with the children's code in multiple ways, and,

j. in such other particulars as may be ascertained through discovery procedures undertaken pursuant to The South Carolina Rules of Civil Procedure.

57. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the standards of care by Defendants Bryant (through York County Sheriff's Department), York County Sheriff's Department, SCDSS and YC, the minor Plaintiff suffered from severe injuries which resulted in brain damage, blindness and catastrophic damages, for which the Plaintiff is entitled to recover on behalf of the minor Plaintiff actual damages and punitive damages in an amount to be determined by a jury at the trial of this action.

FOR A FOURTH CAUSE OF ACTION
(Necessaries Claim – All Defendants)

58. Plaintiff reiterates and realleges paragraphs 1 through 57 as though set forth

herein verbatim, and further alleges:

59. The plaintiff is appearing as the guardian ad litem for the minor plaintiff in this action.

60. The minor plaintiff is in the custody of his maternal grandparents at this time.

61. The minor plaintiff has suffered catastrophic injuries which are going to cause enormous medical and life care expense from the time of injury until his death.

62. The minor plaintiff will incur many of these medical and life care expenses from the time of injury until he reaches the age of eighteen.

63. The medical and life care expenses from time of injury until 18 are typically referred to as a cause of action known as a necessaries claim.

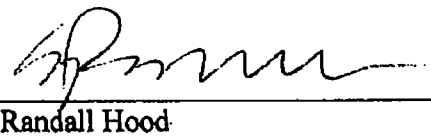
64. The necessaries claim in this case is being prosecuted on behalf of the maternal grandparents and the minor plaintiff by the guardian ad litem in this case.

65. The plaintiff understands that she is prosecuting this action on behalf of the minor child for all of his injuries from the time of inception, until death, including all necessaries claims.

66. The necessaries claims in this case are due to the negligence of all defendants as espoused above.

67. But for the negligence and failure of all defendants to act appropriately or fail to act appropriately, the minor plaintiff has suffered horrific and grievous injuries for which all defendants are liable.

WHEREFORE, Plaintiffs, respectfully pray for judgment against Defendants for all actual damages and consequential damages in an amount to be determined by the jury at the trial of this action, the costs and disbursements of this action and for such other and further relief as this court deems just and proper.



S. Randall Hood
Jordan Calloway
Lara Pettis Harrill
MCGOWAN, HOOD, & FELDER, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732
(803) 327-7800
(803) 328-5656 (Fax)
rhood@mcgowanhood.com
jcalloway@mcgowanhood.com
lharrill@mcgowanhood.com

Duane M. Shaw
Nathan J. Sheldon
SHAW LAW FIRM
1169 Ebenezer Road
Rock Hill, South Carolina 29732
(803) 329-4200
(803) 329-4202 (Fax)
shaw@shawlawfirm.net
sheldon@shawlawfirm.net

Rock Hill, South Carolina

November 30, 2011

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointed Guardian Ad Litem to [redacted] a minor,	)	C.A. Number: 11-CP-46- 04508
Plaintiff	)	**AFFIDAVIT**
v.	)	**GEORGE W. SAVARESE, Ph.D., LCSW**
Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County and The York County Sheriff's Department,	)	
Defendants	)	

FILED-RECEIVED
2011 DEC -1 AM 9:43
DAVID HAMILTON
C.C.C.P.&G.S.
YORK COUNTY, SC

PERSONALLY APPEARED BEFORE ME, THE UNDERSIGNED, BEING DULY SWORN, SAYS AS FOLLOWS:

1. I have a Ph.D. in clinical social work/social administration/social policy analysis, and am a licensed clinical social worker. I have currently and/or in the past provided psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets in the field of social work. I provide forensic consultation services nationally in criminal, civil, and military court proceedings, provided clinical and medical social work services to home health care providers and hospice agencies. Additionally, I am a lecturer and a professor teaching graduate and undergraduate level courses in social intervention, psychopathology and social welfare policy. My education, training and experience are set forth in the attached CV (Exhibit A). It is my belief that my education, training and experience qualify me to render expert opinions in regard to the expected performance standards of the Defendant South Carolina Department of Social Services, the Defendant Carolinas Medical Center, their social workers and discharge planners, and employees and/or agents of each entity who should have operated within the standard of care which would have protected [redacted] in this case.

2. I am familiar with the standard of care of what a reasonably prudent licensed social worker would do or not do in preventing recurrent neglect and abuse of children and protecting the rights of children. Additionally, I am familiar with potential issues/matters that stem from abuse and neglect resulting in hospital admissions, subsequent care, discharge of potentially abused children from a hospital, facilitating after care upon discharge from a hospital, follow up by a state agency whose duty is to protect children, and the concerns of representatives not properly protecting someone like [redacted]

3. I have reviewed the medical records of [redacted] which consisted in part of records from Piedmont Medical Center, Med Center Air, Carolinas Medical Center, Hospice & Community Care, Sunshine Pediatrics, York County DSS, and The York County Sheriff Office report. The records I have reviewed are the type of documents which I would consider in rendering an expert licensed clinical social worker opinion in this case.

4. It is my opinion, within a reasonable degree of professional certainty that the Defendant South Carolina Department of Social Services, Defendant Carolinas Medical Center and their employees and/or agents committed negligent acts or omissions in services and care rendered to [redacted] Without intending to limit the scope of my opinions, some of the specific breaches of the standard of care I have identified as being perpetrated by The South Carolina Department of Social Services, Carolinas Medical Center and their employees and/or agents are as follows:

* In failing to conduct an appropriate and independent psychosocial assessment in order to identify, explore and comprehend the specifics of the risk for child abuse and re-injury related to [redacted]

* In failing to initiate and facilitate an appropriate discharge plan; and

* In failing to protect a vulnerable child from further abuse and neglect;

5. Further, it is my opinion to a reasonable degree of professional certainty that the actions or inactions of the employees and/or agents of the South Carolina Department of Social Services and Carolinas Medical Center contributed to the injuries and damages of [redacted]

6. The factual basis for my opinion about the breaches of the standard of care by the employees and/or agents of the South Carolina Department of Social Services and Carolinas Medical Center are the medical records of [redacted] and the South Carolina (York County) Department of Social Services records of [redacted] The factual basis of my opinions may be supplemented at a later time.

7. This Affidavit is given in compliance with *South Carolina Code of Laws §§* 15-36-100 and 15-79-125 which do not require me to state all negligent acts or omissions by any defendant. Further, I reserve the right to supplement or amend this Affidavit or any testimony by me.

[SIGNATURE PAGE TO FOLLOW]

GEORGE W. SAVARESE, Ph.D., LCSW

Sworn to and signed before me
this 4th day of August, 2011

Notary Public

"OFFICIAL SEAL"
Jennifer N Plohr
Notary Public, State of Illinois
Commission Expires 5/26/2012

My Commission expires: 5/26/2012

George William Savarese, Ph.D., LCSW
637 East Golf Road, Suite 201
Arlington Heights, Illinois 60005
847-791-1950 phone
817-549-6460 efax

EDUCATION

PH.D.
University of Chicago, School of Social Service Administration, Chicago, Illinois
Concentration: Clinical Social Work/Social Administration/Social Policy Analysis
Dissertation: "Practitioner activity in a family-based approach to treatment of the elderly." A content analysis of an inchoate behavioral treatment model designed to train elderly clients and their families how to modify a wide range of problematic behaviors was conducted in an attempt to offset the need for institutional placement.
June, 1989

M.S.W.
New York University, School of Social Work, New York, New York
Concentration: Clinical Social Work/Social Administration
June, 1980

B.A.
City College of New York, School of Liberal Arts, New York, New York
Concentration: Psychology/Sociology
February, 1978

ADMINISTRATIVE EXPERIENCE

Curaeta Care Systems, Park Ridge & Arlington Heights, Illinois
January, 1995 to present

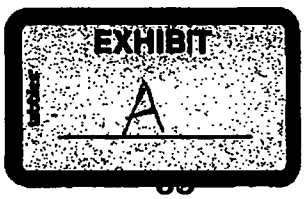
Executive Clinical Director. Founded and direct a private psychosocial services consultation organization which provides psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets; Direct the strategic planning, organizational and program development, research, operations, and supervision of network providers; Provide delivery of direct clinical services through four key programs:

CURAETA*OfCounsel.* Provide forensic consultation services nationally in criminal, civil, and military court proceedings. Services provided include biopsychosocial developmental evaluations, case management services, resource and referral services, research and expert testimony in federal, state, and military jurisdictions. Cases handled include death penalty, death penalty clemency, military courts martial, military separation/discharge, medical malpractice, social work malpractice, immigration, misdemeanor criminal, institutional neglect/abuse, attorney registration and disciplinary hearings, wrongful death, worker's compensation, and personal injury cases.

CURAETA*OnCall.* Provide clinical and medical social work services to home health care providers and hospice agencies as well as behavioral health services for developmentally disabled adults to DHS CILA providers. Services provided include comprehensive psychosocial assessments, behavioral intervention planning, behavioral therapy and counseling, psychosocial risk screening; psychosocial treatment planning and review; case management; information and referral; community resource linkage; crisis intervention; patient and family advocacy; interdisciplinary consultation; discharge planning; post- discharge follow-up; short-term, solution focused counseling; family counseling; behavior modification; case management services for dementia and Alzheimer's patients and their families; and patient and family education.

CURAETA*AtHome*. Provide home-based, neurobehavioral and psychosocial rehabilitation services to patients and their families addressing community-reentry issues associated with traumatic brain injuries, spinal cord injuries, and various other disabling health conditions.

CURAETA*InService*. Provide in-service training and clinical supervision services to various medical facilities, schools, and other health-based and social service organizations.



Texas Research Institute of Mental Sciences, Houston, Texas
July, 1980 to September, 1982

Assistant Administrator, Adult Outpatient Services. Planned, recommended, and coordinated the development of techniques, standards, policies and procedures for the improvement of departmental programs; Reviewed appropriate staffing levels; Assisted in forecasting and budget preparation and control; Consulted with and advised departmental head regarding operational problems; Prepared written reports for staff meetings, governing, and regulating bodies; Represented department in absence of departmental head; Provided consultation to other institute staff in understanding and utilizing departmental services; Worked with and made presentations to civic and professional groups to coordinate, improve, and stimulate appropriate utilization of services; Participated in training projects to promote staff development; Compiled statistical data regarding operation of the department; Designed data collection instruments for departmental management information system; Produced training manuals; Produced staff procedures manual

Coordinator, Central Intake/Information and Referral Services. Coordinated overall intake and referral procedures and scheduling of patients; Direct supervision and evaluation of assigned staff; Recruited and hired staff; Reported human resources logistical needs, requirements and accomplishments; Conducted staff meetings; Reviewed statistical data regarding service operation; Screened new admissions; Interviewed walk-ins; Provided crisis-intervention; Interviewed and screened subjects for psycho-pharmocological research; Developed and maintained community resource database; Reduced 3 month waiting list to 3 weeks

ACADEMIC EXPERIENCE

University of Chicago, School of Social Service Administration, Chicago, Illinois
January, 2002 to present

Lecturer. Teach the graduate-level core curriculum course "Social Interventions: Policies and Programs"; Participate in departmental meetings; Advise and counsel students regarding academic issues

Columbia College Chicago, Chicago, Illinois
January, 2010 to present

Adjunct Professor. Teach the graduate-level core curriculum course "Psychopathology"; Participate in departmental meetings; Advise and counsel students regarding academic issues

Governors State University, College of Health Professions, University Park, Illinois
August, 1989 to December, 1998

Adjunct Professor. Taught the undergraduate-level core curriculum course in Social Welfare Policy; Participated in departmental meetings; Advised and counseled students regarding academic issues; Assisted departmental head in Council on Social Work Education accreditation process

University of Chicago, School of Social Service Administration, Chicago, Illinois
September, 1992 to present

Clinical Field Instructor. Provide clinical field instruction to graduate clinical social work interns in clinical assessment, diagnosis, and research methodologies; Coordinate student involvement in on-going clinical research study evaluating biopsychosocial developmental risk/protective factors associated with violent criminal behavior; Participate in student training workshops

Loyola University, Applied Psychology Program, Evanston, Illinois
September, 1992 to June, 1996

Clinical Field Instructor. Provided clinical field instruction to undergraduate psychology interns in clinical assessment, diagnosis, and research methodologies; Coordinated student involvement in on-going clinical research study evaluating biopsychosocial developmental risk/protective factors associated with violent criminal behavior

University of Illinois, Jane Addams School of Social Work, Chicago, Illinois
September, 2001 to June, 2002

Clinical Field Instructor. Provided clinical field instruction to graduate social work interns in clinical assessment, diagnosis, and research methodologies; Coordinated student involvement in the delivery of medical social work services

Governors State University, College of Health Professions, University Park, Illinois
September, 1993 to June, 1994

Clinical Field Instructor. Provided clinical field instruction to undergraduate clinical social work interns in geriatric assessment, case management, community resource linkage and discharge planning methodologies

TRAINING EXPERIENCE

Private Clinical Social Work Consultation Practice, Park Ridge & Arlington Heights, Illinois
June, 1989 to present

Consultant/Trainer/Workshop Facilitator. Provide a wide range of in-service training workshops and presentations to payers, managed care companies, case management organizations, hospitals, home health agencies, social service agencies, and other human service organizations to include various clinical, medical and forensic social work training presentations, discharge planning, teamwork workshop consultations, and behavioral healthcare presentations

Texas Research Institute of Mental Sciences, Houston, Texas
July, 1980 to September, 1982

Faculty Training Coordinator, Department of Continuing Education. Developed and coordinated various statewide training workshops for Texas Department pf Mental health and Retardation

CLINICAL EXPERIENCE

Curaeta Care Systems, Park Ridge & Arlington Heights, Illinois
January, 1995 to present

Clinical, Medical, and Forensic Social Work Consultation. Provide direct clinical, medical, and forensic social work consultation services through the CURAETA*OfCounsel*, *OnCall*, *AtHome*, and *InService* programs detailed above under "Administrative Experience".

Gentiva Health Services, Home Health Care Division, Hickory Hills, Illinois
January, 1992 to September, 2006

Medical Social Worker. Instructed, treated, observed, and evaluated clients exhibiting significant social and emotional problems affecting their health status; Participated in the development and periodic re-evaluation of the Physician's Plan of Treatment and the Plan of Care for client's needing social work services; Provided ongoing assessment of client/family needs; Utilized appropriate community resources to achieve identified objectives; Participated in case conferences, staff meetings, inservice programs and utilization reviews as appropriate

Gentiva Health Services RehabWithoutWalls, Vernon Hills, Illinois
June, 2001 to July, 2006

Clinical/Medical Social Worker. Provided medical and clinical social work services within a community re-entry model of in-home and on-site rehabilitation services; Participated in interdisciplinary case teleconferences as necessary; Consulted with OT/PT/ST disciplines regarding clients psychosocial needs; Provided in-service training as requested

Private Clinical Social Work Practice, Park Ridge & Arlington Heights, Illinois
March, 1990 to present

Licensed Clinical Social Worker. Provide brief and long-term psychotherapy services for adolescents, adults, couples and families

Texas Research Institute of Mental Sciences, Houston, Texas
July, 1980 to September, 1982

Psychiatric Social Worker, Adult Outpatient Services. Provided psychosocial and diagnostic assessments of patients for inpatient and outpatient treatment based on OSM criteria as part of multi-disciplinary team; Provided brief and long-term psychotherapy services for individual adult outpatients

Family Care Services, Chicago, Illinois
February, 1991 to July, 1993

Clinical Social Worker. Provided home-based, family-centered psychotherapy and counseling services to children and families for a licensed child welfare agency under contract with the Department of Children and Family Services

TakeHeart Program, Chicago, Illinois
July, 1989 to July, 1992

Clinical Social Worker. Provided short-term behavioral modification therapy services related to modifying coronary-prone behavior in cardiac patients; Presented in-service educational training presentations to hospitals and community groups on coronary-prone behavior

University of Chicago, School of Social Service Administration, Chicago, Illinois
January, 1985 to September, 1985

Practitioner/Researcher, Elderly Support Project. Provided behavioral modification treatment and conducted clinical research experiments in behavioral treatment of the elderly and their families; Interviewed and trained subjects in their homes in family-centered behavioral intervention methods; Coded data; Conducted data analyses; Participated in public relations and dissemination of program results with participating agencies

Jewish Family and Community Service, Skokie, Illinois
June, 1983 to September, 1983

Clinical Social Worker, Outpatient Services. As summer intake worker, interviewed and evaluated walk-in clients; Completed psychosocial assessments; Crisis intervention; Psychosocial risk screening (assessed and interpreted data from medical records to determine need for possible social service intervention); Community resource linkage; Provided financial aid and counseling; Screened and assessed telephone inquiries for assistance; Provided brief and long-term psychotherapy for individuals and marital couples

Long Island Jewish Medical Center, Glen Oaks, New York
September, 1979 to May, 1980

Psychiatric Social Work Intern, Adult Outpatient Department. Provided brief and long-term individual, marital and family psychotherapy services for adult outpatients; Organized and ran a treatment group for alcoholic inpatients

Administrative Assistant, Central Intake Department. Conducted telephone interviews with new and prospective patients; Prepared applications for admission; Analyzed patient's financial data and insurance coverage for fee determination; Assisted department chief in administrative matters as requested

Creedmoor Psychiatric Center, Glen Oaks, New York
September, 1978 to May, 1979

Psychiatric Social Work Intern, Adult Inpatient Unit. Provided brief and long-term supportive psychotherapy services for psychotic and schizophrenic inpatients; Ran a remotivational group for severely regressed schizophrenic inpatients; Proposed, developed and implemented a community apartment living program for discharged young adult inpatients

Student Liaison, Queens Field Instructional Center. Assisted in planning, organizing and evaluating training workshops for a network of eight schools of social work; Organized and ran a student peer support group; Negotiated work demands of hospital administrative staff with learning needs of social work interns

RESEARCH EXPERIENCE

Biopsychosocial Developmental Risk Study, Park Ridge & Arlington Heights, Illinois
September, 1992 to present

Principal Investigator. Conduct independent clinical research into biological, psychological and social developmental risk/protective factors associated with violent criminal behavior and other mental/emotional disorders; Currently developing a manuscript of theory, methods, findings and applications related to above research

Ernst & Young, Chicago, Illinois
October, 1984 to February, 1989

Research Associate. Management Consulting Services, Health Care Planning Group. Development of strategic and program plans for hospitals in a variety of competitive situations; Market segmentation and competitor analyses of new business opportunities for major health care systems; Case mix planning analyses; Development of physician and nursing staffing arrangements; Evaluation of institutional demand, utilization, and volume trends; assessment of service area size, population demographics, socioeconomics, area providers, area health factors and growth potential for various multi-hospital health care systems: Certificate of need assistance: Analysis of medical staff practice patterns: Analysis of cost containment measures and rate-setting standards: Telephone survey interviews; Development of a national database of hospital and legislative data to facilitate certificate of need determination: Supervision of temporary personnel and audit staff; Literature reviews; Break-even analyses

Systems Developer. Complete responsibility for definition, design, development, and implementation of customized microcomputer-based financial and database systems for clients and in-house use-Responsibilities included: Assessment of user requirements; Definition of system alternatives; Recommendations for system enhancements based on user needs and/or production efficiency: Design of system architecture; Preparation of preliminary and detail design documentation; Development of work plans for implementation; Estimation of project time and costs; Preparation of progress reports on assigned work: Coding of programs, unit testing, and subsystem integration testing; Preparation of user manuals and source code documentation; Installation of programs; System performance testing; Development of training materials and formal and informal training in system use; Monitoring of system performance and troubleshooting; Communications with corporate personnel at all levels in regard to data processing needs: Evaluation and installation of pre-packaged software products

Chicago Urban League, Research and Planning Department, Chicago, Illinois
August, 1984 to October, 1984

Research Assistant. Chicago Health Care Assessment. Conducted field surveys for health care assessment study of Chicago's south side residents

University of Illinois, Department of Planning and Policy, Chicago, Illinois
May, 1984 to July, 1984

Research Assistant. Urban Community Study. Conducted field surveys for social services utilization trend study of Greater Chicago area

Michael Reese Hospital, Chicago, Illinois
June, 1984 to August, 1984

Consultant, Parent Alliance Study. Conducted in-home clinical interviews of couples as an independent research consultant to assess the qualitative aspects of the parental relationship; Administration of personality inventories and projective tests

Henry Booth House, Chicago, Illinois
November, 1983 to May, 1984

Research Consultant. Conducted research to study the potential for economic development opportunities for single-mother AFDC recipients; prepared final report of study findings (Women, Work & Welfare", Henry Booth House, May, 1984), which was distributed nationally

OTHER EXPERIENCE

Hull House Association, Chicago, Illinois
June, 1983 to January, 1984

Social Worker, Research & Advocacy Department. Assisted in organizing and coordinating Illinois Task Force on Child Support which was instrumental in passing and implementing wage withholding legislation for delinquent child support cases in Illinois; Assisted in developing and participated in provider's seminars and speaker's bureau, making presentations to community groups and employers regarding child support issues; Participated in drafting and editing state paternity legislation

Chicago Jobs Council, Chicago, Illinois
January, 1984 to January, 1985

Editor, "First Source" Newsletter. Developed, edited, wrote, and published community newsletter concerned with public policies affecting job targeting and affirmative action in Chicago

Houston Mental Health Association, Houston, Texas
July, 1981 to July, 1982

Chairperson, Parent Education Subcommittee. Wrote grant proposal for anti-victimization program to prevent sexual abuse of children. Grant was approved for $55,000. Program was implemented in 2,500 classrooms within the Houston Independent School District

Parenting Skills Workshop, Sugarland, Texas
April, 1981 to July, 1981

Consultant/Trainer. Developed, organized and implemented a private parenting skills training workshop for twenty couples, sponsored by the Settler's Park Homeowner's Association

Social Security Administration, Astoria, New York
February, 1976 to August, 1978

Service/Claims Representative. Initiated, adjudicated and serviced benefit claims to Social Security retirement, Medicare, disability, and SSI benefits

VOLUNTARY ACTIVITIES

Testified before Governor Ryan's Prison Review Board/Death Penalty Clemency Hearings, 2002
National Association of Social Workers Task Force on Violence 1995-1997
Testified before Attorney General's Violence to Children Task Force, 1996
Member, Advisory Board, Personal Touch Home Care, Inc., 1995-1997
Member, Advisory Board, Home Health Care, Inc., 1992-1 996
Member, Ethics Committee, Home Health Care, Inc. 1992 to 1996
Member, Utilization Review Committee, Home Health Care, Inc., 1995-1996
Member, Utilization Review Committee, Gentiva Health Services, 1995 to 2006
CAN, Channel 3, "Lifestyle With Pat Cheffer", Chicago, Illinois, 1991
Presenter at Ohio State University Conference on Doctoral Research in Social Work, 1989
Illinois Task Force on Child Support, 1983-1984
Parent Education Subcommittee, Houston mental Health Association, 1981-1 982
Project on Prevention of Mental Illness, Texas Department of Mental Health and Retardation, 1981-1982
KHOU-TV, 'The Warner Roberts Show", Houston Texas, 1981

PUBLICATIONS

Savarese, G.W. (1984). Women, work & welfare. Chicago, Illinois: Henry Booth House.

Savarese, G.W. (1989), A family-based approach to treatment of the elderly., In Social work practice with populations at risk: Proceedings from the fifth national symposium on doctoral research and social work practice. The Ohio State University, College of Social Work, November 8-9, p. 129-142.

MEMBERSHIPS/CERTIFICATIONS/LICENSES

National Association of Social Workers
Academy of Certified Social Workers
Licensed Clinical Social Worker, Doctorate, State of Illinois
American Association of Social Workers in Home Health Care
American Heart Association, Certified CPR & AED Program
Past Registered Speaker, American Heart Association's Speaker's Bureau

STATE OF SOUTH CAROLINA COUNTY OF YORK	)))	IN THE COURT OF COMMON PLEAS
Elizabeth Hope Rainey, as the appointed Guardian ad Litem to [redacted], a minor, Plaintiff, v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County, Defendants.	)	Civil Action No. 11-CP-46-4508 **ANSWER OF DEFENDANT, CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS MEDICAL CENTER**

The defendant, Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, answers the Complaint of the plaintiff as follows:

1. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraph 1 and denies and demands proof of all such allegations.

2. This defendant admits it is a Hospital Authority organized under the law of the State of North Carolina with its principal place of business in Charlotte, North Carolina, and doing business as Carolinas Medical Center.

3-5. The allegations in Paragraphs 3, 4 and 5 relate to other defendants and entities and this defendant does not have sufficient knowledge or information to form a belief as to the truth of those allegations and denies and demands proof of all such allegations.

6. Denied.

7. Denied.

8. Denied.

9. Admitted upon information and belief.

10-11. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 10 and 11 and denies and demands proof of all such allegations.

12-20. This defendant admits that [redacted] presented to the emergency room at CMC on December 4, 2009, was examined, and was admitted to Carolinas Medical Center for examination and treatment. This defendant further admits that a social worker at CMC contacted the York County Division of the South Carolina Department of Social Services and advised that agency that a follow up investigation regarding [redacted] needed to be performed. Except as specifically admitted herein, each and every allegation in Paragraphs 12 through 20 is denied.

21. Denied.

22. Admitted.

23. This defendant admits that a social worker at Carolinas Medical Center contacted the South Carolina Department of Social Services and informed it that an investigation needed to be done regarding the minor plaintiff, but this defendant does not have sufficient knowledge or information to form a belief as to the truth of the remaining allegations in Paragraph 23 and denies all such allegations.

24. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraph 24 and, therefore, denies and demands proof of all such allegations.

25. Denied.

26-29. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 26 through 29 and denies and demands proof of all such allegations.

30. Denied.

31. Denied.

Except as specifically admitted herein, each and every allegation in plaintiff's Complaint is denied.

FOR A FIRST DEFENSE
TO THE FIRST CAUSE OF ACTION

32. This defendant repeats its answers to Paragraphs 1 through 31 and incorporates those answers herein by reference.

33. This defendant admits that when Owen Carduff was at CMC in December of 2009, agents and employees of CMC as well as other physicians and healthcare providers provided care to [redacted]. Except as specifically admitted herein, each and every allegation in Paragraph 33 is denied.

34. Denied.

35. Denied.

36. Denied.

Except as specifically admitted herein, each and every allegation in the plaintiff's first cause of action and in the plaintiff's entire Complaint is denied.

FOR A FIRST DEFENSE
TO THE SECOND CAUSE OF ACTION

37. This defendant repeats its answers to Paragraphs 1 through 36 and incorporates those answers herein by reference.

38. This defendant admits it notified the South Carolina Department of Social Services that the minor plaintiff was a potential victim of child abuse.

39-47. The allegations in Paragraphs 39 through 47 involve another defendant and this defendant does not have sufficient knowledge or information to form a belief as to the truth of those allegations and denies and demands proof of all such allegations.

Except as specifically admitted herein, each and every allegation in the plaintiff's second cause of action and in the plaintiff's entire Complaint is denied.

FOR A FIRST DEFENSE
TO THE THIRD CAUSE OF ACTION

48. This defendant repeats its answers to Paragraphs 1 through 47 and incorporates those answers herein by reference.

49. This defendant admits it notified the South Carolina Department of Social Services that the minor plaintiff was a potential victim of child abuse.

50-57. The allegations in Paragraphs 50 through 57 involve another defendant and this defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 50-57 and denies and demands proof of all such allegations.

Except as specifically admitted herein, each and every allegation in the plaintiff's third cause of action and in the plaintiff's entire Complaint is denied.

FOR A FIRST DEFENSE
TO THE FOURTH CAUSE OF ACTION

58. This defendant repeats its answers to Paragraphs 1 through 57 and incorporates those answers herein by reference.

59-65. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 59 through 65 and denies and demands proof of all such allegations.

66. Denied.

67. Denied.

Except as specifically admitted herein, each and every allegation in the plaintiff's fourth cause of action and in the plaintiff's entire Complaint is denied.

FOR A SECOND DEFENSE
TO ALL CAUSES OF ACTION

68. This defendant will show that if South Carolina Law applies to this case, the plaintiff's claim for non-economic damages is limited by the South Carolina Tort Reform Act.

FOR A THIRD DEFENSE
TO ALL CAUSES OF ACTION

69. This defendant will show that if South Carolina Law applies to this case, the plaintiff's claim is barred by the South Carolina Code Ann. § 63-7-390.

FOR A FOURTH DEFENSE
TO ALL CAUSES OF ACTION

70. This defendant will show that if North Carolina Law applies to this case, the plaintiff's claims for punitive damages are barred or limited by North Carolina's General Statutes Ann. § 1D-1-50.

FOR A FIFTH DEFENSE
TO ALL CAUSES OF ACTION

71. This defendant will show that if North Carolina Law applies to this case, the plaintiff's claims are barred or limited by 2011 N.C. Sess. Laws S.L. 2011-400.

FOR A SIXTH DEFENSE
TO ALL CAUSES OF ACTION

72. If North Carolina Law applies, this defendant will show the plaintiff's claims are barred or limited by N.C. Code § 7B-309.

FOR A SEVENTH DEFENSE
TO ALL CAUSES OF ACTION

73. The plaintiff is not entitled to an award for punitive damages as an award of punitive damages violates the Commerce Clause and Fifth and Fourteenth Amendments of the United States Constitution and Article I, Section 3, of the South Carolina Constitution in that:

(a) the judiciary's ability to correct a punitive damage award at the appellate level only upon a finding of passion, prejudice, or caprice is inconsistent with due process guarantees;

(b) any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;

(c) the jury's unfettered power to award punitive damages in any amount it chooses is wholly devoid of meaningful standards and is inconsistent with due process guarantees;

(d) even if it could be argued that a standard governing imposition of punitive damages exists, the standard is void for vagueness; and

(e) the plaintiff's claim for punitive damages violates the Commerce Clause and Due Process Clause, and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution and Article I, Section 3 of the South Carolina Constitution in that the amount of punitive damages is based upon the wealth and status of the defendant.

WHEREFORE, having fully answered, this defendant prays that the plaintiff's Complaint be dismissed, with costs, and for such other and further relief as the Court deems just and proper.

SOWELL GRAY STEPP & LAFFITTE, L.L.C.

By: _____

Monteith P. Todd
1310 Gadsden Street
Post Office Box 11449
Columbia, South Carolina 29211
(803) 929-1400
Attorneys for Defendant, Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center

Columbia, South Carolina

Jan 10, 2012

STATE OF SOUTH CAROLINA COUNTY OF YORK	)))	IN THE COURT OF COMMON PLEAS
Elizabeth Hope Rainey, as the appointed Guardian ad Litem to [redacted] a minor, Plaintiff, v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County, Defendants.	)	Civil Action No. 11-CP-46-4508 **AMENDED ANSWER OF DEFENDANT, CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS MEDICAL CENTER**

The defendant, Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, answers the Complaint of the plaintiff as follows:

1. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraph 1 and demands proof of all such allegations.

2. This defendant admits it is a Hospital Authority organized under the law of the State of North Carolina with its principal place of business in Charlotte, North Carolina, and does business and operates a hospital in Charlotte, North Carolina, known as Carolinas Medical Center.

17. This defendant admits that [redacted] began to recuperate from the condition which brought him to the hospital on December 5, 2009. Except as specifically admitted, all allegations in Paragraph 17 are denied.

18. This defendant admits Michael Carduff and Kayla Lythgoe were with [redacted] while he was hospitalized in CMC in December 2009, but deny all other allegations in Paragraph 18.

19. This defendant admits that [redacted] was evaluated for non-accidental trauma at CMC, that CMC contacted the South Carolina Department of Social Services regarding a potential for non-accidental trauma, and that [redacted] was discharged on December 8, 2009, after the South Carolina Department of Social Services had evaluated the matter and with the understanding that the mother and father would attend parenting classes, and that the South Carolina Department of Social Services would evaluate [redacted]s home situation. Except as specifically admitted herein, all allegations in Paragraph 19 are denied.

20. Denied.

21. Denied.

22. This defendant admits that CMC contacted the York Division of the South Carolina Department of Social Services and informed it of a potential case of non-accidental trauma and the need for the South Carolina Department of Social Services to investigate the case.

23. This defendant admits that Carolinas Medical Center contacted the South Carolina Department of Social Services and informed it of a potential case of non-accidental trauma and the need for the South Carolina Department of Social Services to investigate the case, but this defendant does not have sufficient knowledge or information to form a belief as to the truth of the remaining allegations in Paragraph 23 and denies all such allegations.

24. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraph 24 and denies and demands proof of all such allegations.

25. Denied.

26. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 26 through 29 and denies and demands proof of all such allegations.

27. Admitted, upon information and belief.

28. This defendant admits [redacted] had life threatening injuries when he presented to CMC on January 11, 2010, but survived those injuries. This defendant denies all other allegations in Paragraph 28.

29. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraph 29 and denies and demands proof of those allegations.

30. Denied.

31. Denied.

Except as specifically admitted herein, each and every allegation in plaintiff's Complaint is denied.

FOR A FIRST DEFENSE
TO THE FIRST CAUSE OF ACTION

32. This defendant repeats its answers to Paragraphs 1 through 31 and incorporates those answers herein by reference.

33. This defendant admits that when [redacted] was at CMC in December of 2009, agents and employees of CMC as well as other physicians and healthcare providers

provided care to [redacted] Except as specifically admitted herein, each and every allegation in Paragraph 33 is denied.

34. Denied.

35. Denied.

36. Denied.

Except as specifically admitted herein, each and every allegation in the plaintiff's first cause of action and in the plaintiff's entire Complaint is denied.

FOR A FIRST DEFENSE
TO THE SECOND CAUSE OF ACTION

37. This defendant repeats its answers to Paragraphs 1 through 36 and incorporates those answers herein by reference.

38. This defendant admits it notified the South Carolina Department of Social Services of the potential that [redacted] had suffered non-accidental trauma, but denies all other allegations in Paragraph 38.

39-47. The allegations in Paragraphs 39 through 47 involve another defendant and this defendant does not have sufficient knowledge or information to form a belief as to the truth of those allegations and denies and demands proof of all such allegations.

Except as specifically admitted herein, each and every allegation in the plaintiff's second cause of action and in the plaintiff's entire Complaint is denied.

FOR A FIRST DEFENSE
TO THE THIRD CAUSE OF ACTION

48. This defendant repeats its answers to Paragraphs 1 through 47 and incorporates those answers herein by reference.

49. This defendant admits it notified the South Carolina Department of Social Services of the potential that [redacted] had experienced non-accidental trauma during the time [redacted] was hospitalized at CMC during December 2009, but denies all other allegations in Paragraph 49.

50-57. The allegations in Paragraphs 50 through 57 involve another defendant and this defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 50-57 and denies and demands proof of all such allegations.

Except as specifically admitted herein, each and every allegation in the plaintiff's third cause of action and in the plaintiff's entire Complaint is denied.

FOR A FIRST DEFENSE
TO THE FOURTH CAUSE OF ACTION

58. This defendant repeats its answers to Paragraphs 1 through 57 and incorporates those answers herein by reference.

59-65. This defendant does not have sufficient knowledge or information to form a belief as to the truth of the allegations in Paragraphs 59 through 65 and denies and demands proof of all such allegations.

66. Denied.

67. Denied.

Except as specifically admitted herein, each and every allegation in the plaintiff's fourth cause of action and in the plaintiff's entire Complaint is denied.

FOR A SEVENTH DEFENSE
TO ALL CAUSES OF ACTION

73. The plaintiff is not entitled to an award for punitive damages as an award of punitive damages violates the Commerce Clause and Fifth and Fourteenth Amendments of the United States Constitution and Article I, Section 3, of the South Carolina Constitution in that:

(a) the judiciary's ability to correct a punitive damage award at the appellate level only upon a finding of passion, prejudice, or caprice is inconsistent with due process guarantees;

(b) any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;

(c) the jury's unfettered power to award punitive damages in any amount it chooses is wholly devoid of meaningful standards and is inconsistent with due process guarantees;

(d) even if it could be argued that a standard governing imposition of punitive damages exists, the standard is void for vagueness; and

(e) the plaintiff's claim for punitive damages violates the Commerce Clause and Due Process Clause, and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution and Article I, Section 3 of the South Carolina Constitution in that the amount of punitive damages is based upon the wealth and status of the defendant.

WHEREFORE, having fully answered, this defendant prays that the plaintiff's Complaint be dismissed, with costs, and for such other and further relief as the Court deems just and proper.

SOWELL GRAY STEPP & LAFFITTE, L.L.C.

By: Monty Todd

Monteith P. Todd
1310 Gadsden Street
Post Office Box 11449
Columbia, South Carolina 29211
Attorneys for Defendant, Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center

February 1, 2012

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointment Guardian ad Litem to [redacted] a minor,	)	Civil Action No.: 2011-CP-46-04508
Plaintiff,	)	
vs.	)	**ANSWER OF THE DEFENDANT SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES**
Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, South Carolina Department of Social Services, Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County,	)	
Defendants.	)	

FILED-RECEIVED
2012 JAN 11 AM 10:47
DAVID HAMILTON
C.C.C.P.&G.S.
YORK COUNTY, SC

The Defendant South Carolina Department of Social Services (hereinafter, SCDSS) answering the Complaint of the Plaintiff, alleges as follows: Lexington, South Carolina. Lexington, South Carolina.

FOR A FIRST DEFENSE

1. Each and every allegation of the Complaint not specifically admitted, qualified, nor otherwise explained herein, is denied.

2. This Defendant admits so much of paragraphs 3, 6, 7, 39, 43, and 44 of the Complaint as alleges that this Defendant is an agency of the State of South Carolina, subject to suit under the terms, conditions, and limitations of the South Carolina Tort Claims Act, codified at *S.C. Code Ann.* §§ 15-78-10, through -220 (1986 as amended), and empowered by statute and regulation with authority, duties, and responsibilities set forth by such statute and regulation; and this Defendant does crave reference to such

statutes and regulations for an accurate enumeration of this Defendant's duties and responsibilities. The remaining allegations of paragraphs 3, 6, 7, 39, 43, and 44 are denied as to this Defendant.

3. This Defendant admits so much of paragraph 22 of the Complaint as alleges or infers that this Defendant's York County office received an intake report involving the minor child subject of this action on December 6, 2009, at 5:01 p.m.

4. This Defendant admits so much of paragraphs 24 and 50 to the extent that they allege that, as part of this Defendant's investigation prompted by the December 6, 2009 intake report, this Defendant faxed or otherwise delivered to Law Enforcement Agencies, including the York County Sheriff's Department, Requests for Criminal History/Incident Reports for Michael Carduff, Kayla Lythgoe, and Charlotte Williams on or about December 16, 2009, and pursuant to *S.C. Code Ann.* § 20-7-650, notified the York County Sheriff's Department that there appeared to be a violation of criminal law involving Owen Carduff, without mentioning a suspect. The remaining allegations of paragraphs 24 and 50 are denied.

5. This Defendant admits so much of paragraph 26 of the Complaint as alleges that this Defendant received a report that the child was hospitalized again for injuries sustained on or about January 11, 2010, and that, on information and belief, Michael Carduff confessed to injuring the child.

6. This Defendant admits so much of paragraphs 38 and 49 of the Complaint as alleges or infers that this Defendant's York County office received an intake report on December 6, 2009 at 5:01 p.m., the on-call caseworker responded to the Charlotte Hospital commencing the investigation by 7:45 p.m., getting information from the parents, the paternal grandparents, and the paternal uncle of the child, as well as a

nurse—which nurse informed this Defendant's caseworker that the health care workers had no known concerns of non-accidental trauma. This Defendant further affirmatively alleges that one of this Defendant's supervisors followed up the following day by speaking with a health care social worker at the hospital, who had been working with the family, and stated that, as of December 7, 2009, the hospital could not determine if the child's injuries were accidental or non-accidental, 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. This Defendant further affirmatively alleges that, upon inquiring of the doctor who was working with the child, this Defendant's supervisor was told that the doctor could not determine whether the injuries were accidental or not at that point.

7. This Defendant lacks sufficient information to admit or deny the allegations of paragraphs 1, 2, 4, 5, 9, 16, 59, 60, 64, and 65 of the Complaint, and therefore denies the same and demands strict proof thereof.

8. This Defendant denies the allegations of paragraphs 10, 11, 12, 13, 14, 15, 17, 19, 27, 28, 29, 61, 62, and 63 of the Complaint to the extent that they purport to paraphrase or select out-of-context quotations from correspondence, medical records, or other documents relating to the minor child's injuries or medical condition, diagnosis, or prognosis; and this Defendant craves reference to the full text of such medical records for an accurate enumeration of the message conveyed.

9. This Defendant denies the allegations of paragraph 45 of the Complaint insofar as they purport to paraphrase the law or reach legal conclusions, and this Defendant craves reference to the applicable legal authority for an accurate enumeration of the law.

10. This Defendant denies the allegations of paragraph 18 of the Complaint, and affirmatively alleges that this Defendant's caseworker and supervisor were told by hospital staff as of December 7, 2009, that the hospital was unsure as to whether the cause of the child's December 4, 2009 injuries was accidental or non-accidental, that, while they could not rule out trauma, the family did not appear to have a history of trauma, and that the hospital's main concern was lack of supervision by the young parents.

11. This Defendant denies the allegations of paragraphs 23 and 25 of the Complaint, and affirmatively alleges that this Defendant responded to the intake report in a timely manner, began its investigation by making initial contact with the parents, hospital staff, and collaterals the same day as the intake report, with appropriate follow-up, and received information that was inconclusive as to whether the injuries to the child were accidental or non-accidental. This Defendant further affirmatively alleges that it conducted an appropriately thorough and timely investigation, and took appropriate steps to protect the child, given the information that was available at the time.

12. This Defendant denies the allegations of paragraphs 39, 40, 41, 43, and 44 of the Complaint, and affirmatively alleges that this Defendant's York County office received an intake report on December 6, 2009 at 5:01 p.m., the on-call caseworker responded to the Charlotte Hospital commencing the investigation by 7:45 p.m., getting information from the parents, the paternal grandparents, and the paternal uncle of the child, as well as a nurse—which nurse informed this Defendant's caseworker that the health care workers had no known concerns of non-accidental trauma. This Defendant further affirmatively alleges that one of this Defendant's supervisors followed up the following day by speaking with a health care social worker at the hospital, who had been

working with the family, and stated that, as of December 7, 2009, the hospital could not determine if the child's injuries were accidental or non-accidental, 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. This Defendant further affirmatively alleges that, upon inquiring of the doctor who was working with the child, this Defendant's supervisor was told that the doctor could not determine whether the injuries were accidental or not at that point. The remaining allegations of paragraphs 23 and 25 are denied.

13. This Defendant is informed and believes that paragraphs 20, 21, 33, 34, 35, 36, 51, 52, 53, 55, 56, and 57 of the Complaint allege acts or omissions on the part of other Defendants, in concert with or independent of this Defendant; and to the extent that such paragraphs allege liability on the part of this Defendant, those allegations are denied.

14. The allegations of paragraphs 42, 46, 47, 54, 66, and 67 of the Complaint are denied insofar as they apply to this Defendant.

15. This Defendant denies the allegations of paragraphs 30 and 31 of the Complaint.

16. The allegations of paragraphs 32, 37, 48, and 58 require no response, but to the extent that they may be deemed to allege acts or omissions on the part of this Defendant that purport to establish liability on the part of this Defendant, they are denied.

FOR A SECOND DEFENSE

17. The allegations of paragraphs 1 through 16 of the First Defense are re-asserted and re-alleged as fully as if set forth verbatim herein insofar as they are not inconsistent with this Second and affirmative Defense.

18. This Defendant is informed and believes that any damage or injury complained of by the Plaintiff was proximately caused by intervening acts or omissions of third parties other than this Defendant, which were negligent, grossly negligent, willful, wanton, and reckless, not to mention criminal, and were not reasonably foreseeable by this Defendant given the facts and circumstantes then existing; and this Defendant does plead such intervening negligence, gross negligence, and criminal acts of third parties as an affirmative defense and complete bar to recovery.

FOR A THIRD DEFENSE

19. The allegations of paragraphs 1 through 18 of the First and Second Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein insofar as they are not inconsistent with this Third and affirmative Defense.

20. This Defendant is informed and believes that, as an agency of the State of South Carolina, this Defendant is entitled to certain limitations, immunities, and defenses to the Plaintiffs' claims under the South Carolina Tort Claims Act, codified at *S.C Code Ann.* §§15-78-10 through -220 (1985 as amended), including, without limitation, immunities and defenses afforded by *S.C. Code Ann.* §15-78-60 (1), (2), (3), (4), (5), (12), (20), (23), and (25), and to the extent that such immunities and defenses are available to it, this Defendant pleads the various defenses and immunities afforded by the South Carolina Tort Claims Act as an affirmative defense to the claims alleged by the Plaintiff.

FOR A FOURTH DEFENSE

21. The allegations of paragraphs 1 through 20 of the First, Second, and Third Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein insofar as they are not inconsistent with this Fourth and affirmative Defense.

22. To the extent that the Plaintiff seeks punitive damages from this Defendant, this Defendant is informed and believes that, under the terms, conditions, limitations, and exceptions of the South Carolina Tort Claims Act, no award for damages shall include punitive nor exemplary damages; and this Defendant is informed and believes that the Plaintiff's prayer for punitive damages against this Defendant is barred by *S.C. Code Ann.* § 15-78-120(b).

WHEREFORE, having fully answered the Complaint of the Plaintiff, this Defendant prays that the same be dismissed with costs assessed to the Plaintiff, and for such other and further relief as the Court may deem appropriate.

DAVIS, FRAWLEY, ANDERSON, MCCAULEY,
AYER, FISHER & SMITH, LLC.

By: _____

Patrick J. Frawley
Erica M. Parker
140 East Main Street, Post Office Box 489
Lexington, South Carolina 29072
Phone No.: (803) 359-2512
ATTORNEYS FOR THE DEFENDANT
SOUTH CAROLINA DEPARTMENT OF
SOCIAL SERVICES

Lexington, South Carolina
January 9 2012

STATE OF SOUTH CAROLINA	)	IN THE FAMILY COURT
	)	
COUNTY OF YORK	)	CASE NO.: 2011-CP-46-4508

ELIZABETH HOPE RAINEY, as the appointed Guardian ad Litem to [redacted], a minor,

PLAINTIFF,

-vs-

CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS MEDICAL CENTER, SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES, BRUCE BRYANT, as the Constitutional Office of the Sheriff of York County, and THE YORK COUNTY SHERIFF'S DEPARTMENT,

DEFENDANTS.

TRANSCRIPT OF RECORD

April 18, 2013
Rock Hill, South Carolina

B E F O R E:

Honorable S. Jackson Kimball, III, Judge.

A P P E A R A N C E S:

Mr. S. Randall Hood
Attorney at Law
Attorney for the Plaintiff
Rock Hill, South Carolina

Mr. Monteith Powell Todd
Attorney at Law
Attorney for Charlotte-Mecklenburg Hospital Authority
Columbia, South Carolina

Mr. Patrick J. Frawley
Attorney at Law
Attorney for S.C. Department of Social Services
Lexington, South Carolina

Ms. Janet Brooks Holmes
Attorney at Law
Attorney for York County Sheriff's Department
and Bruce Bryant
Columbia, South Carolina

Shannon McGilberry, Court Reporter

COPY

1 THE COURT: All right. This is case number 2011-CP-46-
2 4508, Elizabeth Hope Rainey, by Guardian ad Litem -- as
3 Guardian ad Litem, I mean, against Charlotte-Mecklenburg
4 Hospital Authority and others. Present, representing the
5 plaintiffs, Mr. Randy Hood.
6 Are you Mr. Todd?
7 MR. TODD: I am Mr. Todd, Your Honor.
8 THE COURT: Mr. Monteith P. Todd. This is the
9 defendant's -- Charlotte-Mecklenburg Hospital Authority's
10 motion for summary judgment. Mr. Todd, if you're ready, go
11 ahead.
12 MR. TODD: Yes, sir, Your Honor. Thank you. Your
13 Honor, I filed this motion on behalf of Charlotte-
14 Mecklenburg Hospital on two grounds, one, that the
15 plaintiffs cannot show any duty that was breached and, two,
16 on immunity.
17 The facts of the case are, and I would think that there
18 won't be any -- we stipulate to these certain facts, that
19 [redacted] was a three-month-old child in December of
20 2009. There was some event at home and his parents took him
21 to Piedmont Medical Center. From Piedmont Medical Center,
22 he was transferred to Charlotte-Mecklenburg Hospital,
23 Levine's Children's Hospital. After initial workup, a CT
24 scan revealed that he had a subdural hematoma.
25 THE COURT: Right.

1 MR. TODD: There was no good explanation from the
2 parents as to how that got there. That subdural hematoma
3 led Charlotte-Mecklenburg Hospital -- raised a suspicion of
4 non-accidental trauma, child abuse.
5 Charlotte-Mecklenburg Hospital called the South
6 Carolina DSS, the York County DSS, and reported its
7 suspicion of a non-accidental trauma. DSS began its
8 investigation. It was a Sunday night when the call was
9 made. The investigation was started that Sunday night.
10 DSS continued its investigation. Charlotte-Mecklenburg
11 Hospital, the doctors there, continued to do a workup and
12 there were additional studies, additional evaluations,
13 which, for all intents and purposes, were normal.
14 At the end of the medical workup, the attending
15 physician --
16 THE COURT: As I understood it, they couldn't -- they
17 didn't find anything -- anything to cause the subdural
18 hematoma; right?
19 MR. TODD: No, sir.
20 THE COURT: No bruises, no scratches, nothing?
21 MR. TODD: They was no -- they were not determined --
22 the cause was not determined and at the end of it when they
23 done the --
24 THE COURT: And the result of the neurological exam was
25 within normal limits; right?

1 MR. TODD: Yes, sir.
2 THE COURT: All right.
3 MR. TODD: And at the end of -- when the tests had been
4 done, they'd done these additional tests, the full-body scan
5 and ophthalmological exam, the result was that the doctors
6 could not say that it was child abuse.
7 THE COURT: What did the body scan and the
8 ophthalmological exam reveal, if anything? I didn't see
9 that.
10 MR. TODD: Yes, sir. It -- the body scan was normal.
11 There were no other -- no indication of any breaks or
12 bruises. The ophthalmological scan -- I'm having a hard
13 time saying it. When the court reporter types it out,
14 hopefully, she'll help me out there.
15 THE COURT: Shannon's not saying it, either.
16 MR. TODD: What they're looking for is retinal
17 hemorrhages, because retinal hemorrhages can be a sign of
18 shaken baby.
19 THE COURT: Right.
20 MR. TODD: There were no retinal hemorrhages.
21 THE COURT: Okay.
22 MR. TODD: So at the end of the day, the doctors
23 couldn't say -- they said we cannot rule out accidental
24 trauma or we can't rule out non-accidental trauma. We can't
25 make a definitive statement either way.

1 THE COURT: Well, let me ask you this based on what Mr.
2 Hood sent me. What is the status of a patient, a child, who
3 comes to CMC -- well, let me back up. How did Piedmont
4 refer the child to CMC?
5 MR. TODD: Well, Piedmont did -- well, they referred
6 him by ambulance. That's really what you --
7 THE COURT: That's how they transported him; no?
8 MR. TODD: What happened is Piedmont -- the child -- if
9 you look at the records from Piedmont,---
10 THE COURT: Right.
11 MR. TODD: ---the child was doing well at Piedmont.
12 There was, essentially, a pretty normal exam at Piedmont.
13 They did a spinal tap at Piedmont and the spinal tap
14 revealed blood in the spinal fluid---
15 THE COURT: All right.
16 MR. TODD: ---and that was what led to the transfer to
17 Charlotte-Mecklenburg Hospital.
18 THE COURT: And why?
19 MR. TODD: I guess --
20 THE COURT: Well, why, but why does blood in the spinal
21 fluid -- I mean, if you or I showed up at Piedmont with
22 blood in the spinal fluid, would they refer us to CMC?
23 MR. TODD: Your Honor, we've not deposed the doctors at
24 Piedmont Medical Center based on what I --
25 THE COURT: In other words, was the referral for an

1 evaluation for abuse -- I'll just ask it straight up. Was
2 it a referral for an evaluation for abuse or a referral for
3 a medical reason only?
4 MR. TODD: For a medical reason.
5 THE COURT: All right.
6 MR. TODD: And I'm getting ahead of myself, but there's
7 certain -- if there's a suspicion of child abuse, then
8 certain persons are required to report. There's a reporting
9 statute---
10 THE COURT: Right.
11 MR. TODD: ---that sets it forth.
12 THE COURT: Right.
13 MR. TODD: If Piedmont had suspected child abuse, then
14 they would have had the obligation to report.
15 THE COURT: All right.
16 MR. TODD: So I think what the answer to your question
17 is there was no suspicion by Piedmont, because Piedmont made
18 no report.
19 THE COURT: All right.
20 MR. TODD: Now, there was some testimony from the
21 mother about police officers being there at Piedmont, but we
22 really don't know that. We do know that there was no report
23 from Piedmont to DSS.
24 THE COURT: As required by statute.
25 MR. TODD: As required by statute.

1 THE COURT: All right. Go ahead.

2 MR. TODD: So getting back, when the child was ready
3 for discharge, the social workers advised DSS that the
4 doctors had done the workup, we can't rule it out, we can't
5 rule it in. DSS advised Carolinas Medical Center, Levine's
6 Children's Hospital to discharge the child to his parents.
7 They were going to continue their investigation.

8 THE COURT: Now, how was that advice given?

9 MR. TODD: It was given by --

10 THE COURT: Or direction given.

11 MR. TODD: That direction was given by phone call from
12 the DSS worker to the social worker at Carolina -- at
13 Levine's Children's Hospital.

14 THE COURT: Okay.

15 MR. TODD: As a result, the child was discharged to his
16 parents. DSS had their investigation ongoing and, in fact,
17 later reported to the Sheriff's Department, later did a home
18 study and, in fact, when the child returned in January with
19 the---

20 THE COURT: Serious --

21 MR. TODD: ---serious catastrophic brain injury, DSS's
22 investigation was still going on.

23 THE COURT: All right.

24 MR. TODD: So I think those are facts that the
25 plaintiff will not contest.

1 THE COURT: So DSS, in connection with this incident,
2 didn't seek any kind of Court Order removing the child
3 temporarily while there was an investigation?
4 MR. TODD: No, sir.
5 THE COURT: All right.
6 MR. TODD: Getting back to our argument in this case,
7 it relates to a question of duty and a question of immunity.
8 Basically, what the plaintiff's argument is, what their
9 theory is, the crux of their case is that Carolinas Medical
10 -- Levine's Children's Hospital, Carolinas Medical Center,
11 should have taken some action that would have caused DSS or
12 would have led to this child being removed from the custody
13 of his parents.
14 THE COURT: Or not -- well, as I read it, the hospital
15 shouldn't have released the child to his parents. Is that
16 right, Mr. Hood?
17 MR. HOOD: Yes, Your Honor. That's part of what we're
18 saying.
19 MR. TODD: Right. Well, that gets to the duty
20 question.
21 THE COURT: Well, sure.
22 MR. TODD: This child was ready for discharge---
23 THE COURT: Sure.
24 MR. TODD: ---medically. The child was medically
25 stable and under South Carolina statutes, there is a

1 Children's Code, which is set forth at 63-7-10, ed. sec., it
2 sets forth what the duties and the obligation are of
3 individuals -- of entities when there's a suspicion of child
4 abuse and the first obligation is if you suspect it is to
5 report and in that case there's no question that this was
6 done.
7 Now, there is a -- it's an interesting and it's not
8 really applicable to this case, but there is a Supreme Court
9 -- a South Carolina Supreme Court case where they say the
10 obligation -- or the failure to report does not lead to a
11 civil cause of action. That's Doe versus Marion and it's
12 set forth in my brief.
13 But anyway, in this case, a report was made and so the
14 hospital complied with its obligations to report and they
15 provided the information about the medicine, the medical
16 condition and their opinions to DSS, but what the hospital
17 cannot do is they cannot remove a child from the custody of
18 his parents.
19 They cannot -- you know, and the failure -- I mean, I
20 don't know what the plaintiff's argument is, maybe they
21 should have kept the child in the hospital forever. I mean,
22 I guess if you take their argument to the extreme, that's
23 what it is, but that would be false imprisonment or
24 kidnapping. The child was ready for discharge. DSS advised
25 the hospital to discharge the child to his parents and so

1 their obligation --

2 THE COURT: And there's no dispute about that?

3 MR. TODD: There's no dispute about that. It's in the

4 testimony of DSS and we've got these depositions we can, you

5 know, can hand up, but there's no dispute that DSS advised

6 them to discharge the child to his parents and that was

7 done.

8 The plaintiff's argument is that somehow there should

9 have been some additional investigation and additional

10 information presented to DSS, but still, the obligation --

11 the decision about the family relationship, the decision to

12 remove the child from his parents, that's not for a private

13 entity. That is something that's a state entity and this

14 children's code sets it out and it says -- it sets forth the

15 statutes, if it's law enforcement, if it's DSS, exactly how

16 that is to be accomplished and, ultimately, it would be a

17 decision for the Family Court, unless the parents consented

18 to the removal of the child.

19 THE COURT: Okay.

20 MR. TODD: But anyway, the report was made and DSS, as

21 it was their obligation to do, it was their duty to do, made

22 the decision and gave the instruction. So the plaintiff

23 makes the argument about duty, as near as I can tell it, on

24 two things: on expert testimony and on internal procedures.

25 Now, we've cited the cases that the question of duty is

1 one for the Court. You cannot create a duty through expert
2 testimony.
3 The first case on that was Trotter versus State Farm,
4 which is a 1987 case. It was actually my case. It's a
5 Court of Appeals case, where -- it had to do with an
6 insurance agent and the insurance agent's duty to give
7 advice concerning an insurance policy and in that case the
8 plaintiff had multiple experts, but the Court of Appeals
9 said you cannot create a duty by expert testimony. It is a
10 question for the Court.
11 THE COURT: Question of law.
12 MR. TODD: Question of law for the Court. Same thing
13 in two other cases cited. They seek to create a duty
14 through internal procedures. Howe versus State Farm; that's
15 another one of my cases. You cannot create a duty through
16 internal policies and procedures, just as you cannot create
17 a duty through expert testimony, through advertisements,
18 through anything. It is a question for the Court, a
19 question of law, and the duties are set forth in the
20 children's code. A private individual, a private hospital,
21 cannot make -- cannot remove a child from his parents.
22 Now, they do, under that statute, have -- in North
23 Carolina they have allowed for a twelve-hour emergency
24 custody.
25 THE COURT: Well, he's relying on South Carolina law.

1 MR. TODD: In South Carolina it's twenty-four hours,
2 but you can hold the child until law enforcement comes in
3 and makes a decision.
4 THE COURT: Wasn't this child -- this child was in the
5 hospital for a day so?
6 MR. TODD: The child was in the hospital for --
7 THE COURT: I thought I got that -- I figured that out.
8 It was more than --
9 MR. HOOD: It was the 5th through the 8th.
10 THE COURT: Huh?
11 MR. HOOD: Fifth through the 8th.
12 THE COURT: Yeah. Okay. I thought -- it was multiple
13 days, so that doesn't matter anyway.
14 MR. TODD: It was December the 5th until December the
15 9th.
16 THE COURT: The child was in the hospital over a period
17 of time before they released him to his parents?
18 MR. TODD: Yes, sir.
19 THE COURT: Okay.
20 MR. TODD: And, you know, it was a month or so before
21 the child was brought back. So anyway, the question of
22 duty, but it set forth you cannot create a duty through
23 expert testimony, through internal policies and procedures.
24 That's set forth in the cases we've cited.
25 THE COURT: But what does -- and I don't know if it

1 matters. Upon what basis or -- I don't want to call it a
2 pretext, but upon what basis did CMC keep the child for the
3 number of days that -- just running tests all that time?
4 MR. TODD: They were doing the workup to make sure --
5 you know, the child came in with the subdural hematoma.
6 THE COURT: There's no -- no treatment administered
7 during that time?
8 MR. TODD: Really minimal treatment. It was mostly an
9 evaluation and a workup.
10 THE COURT: All right. Go ahead.
11 MR. TODD: Okay. I think I've addressed the duty.
12 It's a question of the Court and in this case there's no
13 duty.
14 Now, the other ground is immunity, which is set forth
15 clearly --
16 THE COURT: Why doesn't -- and I'm forgetting the
17 phraseology now, but why doesn't the -- or how does the law
18 that surrounds a non-delegable duty, like in the hospital
19 cases where somebody that doesn't work for the hospital
20 commits the tort, but the hospital is nevertheless
21 responsible? I know there was a -- actually, that case had
22 to do with an architect, didn't it?
23 MR. TODD: Well, there's a -- I'm not sure what case
24 you're talking about. It may be --
25 THE COURT: It was Baptist Hospital, I think, in

1 Columbia. I can't -- I'm bad about the names of cases, but
2 the point was that the contractor, I believe, had a non-
3 delegable duty. Anyway, address that, 'cause he claims
4 that, a non-delegable duty.
5 MR. TODD: Your Honor, I've got to confess. I'll have
6 to read that case.
7 MR. HOOD: Your Honor, what we're saying is that the
8 hospital has a duty and we've listed the cases, including
9 non-delegable duty. You can't delegate --
10 THE COURT: Okay. I'll hear --
11 MR. HOOD: Yes, Your Honor.
12 MR. TODD: Well, in this case it's not -- the decision
13 about removal of the child, the decision of what to do with
14 the child and his parents is with DSS. The State and the
15 legislature has clearly said that is where the duty lies.
16 It is not a duty which is imposed on the hospital, CMC to
17 begin with, so there's no duty. It's not a question where
18 -- you know, it's not a question of non-delegable duty,
19 'cause there's no duty to begin with.
20 THE COURT: Well, I think that's the argument they made
21 in the non-delegable duty cases. The other person had a
22 duty, but we didn't.
23 MR. TODD: Well, in the case -- you know, the case I'm
24 familiar with, the Tumi case, there was an apparent agency
25 argument there, but I really would have to read the Baptist

1 case you're referring to.
2 THE COURT: I think it was Baptist. Go ahead. I'm
3 sorry.
4 MR. TODD: I'm vaguely familiar with the case, but I've
5 not read the decision to be able to address it with you. I
6 understand there was a contractor or vendor who was
7 unloading --
8 THE COURT: A vendor.
9 MR. TODD: -- who was unloading something on -- for
10 Baptist. Baptist had said this is where you do the
11 unloading and so -- but I just don't know enough about the
12 case to address it.
13 THE COURT: That's fine.
14 MR. TODD: And I'll be happy to go home, go back to my
15 office, read the case and --
16 THE COURT: No. Mr. Hood can tell me about it.
17 MR. TODD: Okay. The other thing is in section 63-390
18 there's immunity the legislature clearly sets forth.
19 THE COURT: Yeah; 390. Right.
20 MR. TODD: It says, a person required or permitted to
21 report, pursuant to section 63-7-310, or who participates in
22 an investigation or judicial proceeding resulting from the
23 report, acting in good faith, is immune from civil and
24 criminal liability.
25 Now, what -- in their brief they don't address the

1 phrase who participates in the investigation and the theory
2 in this case is that CMC, by providing information to DSS,
3 is liable because they didn't provide enough information for
4 DSS to make the decision to remove the child from the home,
5 but this statute, the clear wording of the statute, provides
6 the hospital immunity.
7 THE COURT: Okay. Mr. Hood.
8 MR. HOOD: Your Honor, as opposed to going through all
9 the stuff that I put in my brief, I'm going to address the
10 arguments of Mr. Todd, because I think it would be much more
11 succinct.
12 Here's the case, Your Honor, I would like for you to
13 look at and this is a case -- we looked everywhere for
14 something that would have some applicability and this is the
15 closest thing we could find in the state of South Carolina
16 and this is where there was a mentally --
17 THE COURT: Let me sure about -- before you start in,
18 is there any distinction you want to make about the facts
19 that he recited?
20 MR. HOOD: Just the fact that this child was sent from
21 Piedmont Medical Center and whether Piedmont Medical Center
22 sent him up there for abuse or for further treatment, that's
23 not been said anywhere. Piedmont could have decided not to
24 make a call or they could have negligently failed to make a
25 call, but it doesn't mean that --

1 THE COURT: Well, what do you know about why the child
2 was sent from Piedmont?
3 MR. HOOD: We just know that he was sent because there
4 was a bloody tap,---
5 THE COURT: Okay.
6 MR. HOOD: ---which would indicate either one of two
7 things. There's probably either some cerebral vascular
8 accident or there may be some type of meningitis.
9 THE COURT: Sure.
10 MR. HOOD: And so it's one of those two things. If
11 they suspected cerebral vascular accident, --
12 THE COURT: So they sent him to Levine because it's a
13 specialty place?
14 MR. HOOD: It's a specialty place, but also, you know,
15 if it's a -- if he's got a brain bleed, better to get him up
16 there with a pediatric neurosurgeon---
17 THE COURT: Right.
18 MR. HOOD: ---who can address that. Now, whether --
19 now, in the policies of Levine Children's Hospital -- and we
20 haven't gotten the policies from Piedmont since we haven't
21 made any allegations against them -- it says any child
22 between the ages of zero and six months who presents with an
23 injury, it is a suspicion of abuse is confirmed. That's it.
24 THE COURT: Say that again.
25 MR. HOOD: Yes, Your Honor.

1 THE COURT: I didn't read these --
2 MR. HOOD: Let me read it from their own --
3 THE COURT: -- all the pages you gave me. I read part
4 of them.
5 MR. HOOD: Let me right from the pages, Your Honor.
6 THE COURT: Which page are you on? Are you in your
7 notebook?
8 MR. HOOD: Yes, Your Honor. I'm under B-3.
9 THE COURT: B-3; yes, sir.
10 MR. HOOD: Excuse me. Not confirmed, suspicious for
11 child abuse.
12 THE COURT: B-3 what?
13 MR. HOOD: Roman numeral I, Your Honor.
14 THE COURT: Roman numeral I.
15 MR. HOOD: It says child physical abuse.
16 THE COURT: Hold on one second. Exhibit -- I'm in
17 Exhibit 3; right? I don't see Roman numeral I.
18 MR. HOOD: I'm sorry, Your Honor. It's under 3 and
19 page -- I'm sorry, Your Honor. I gave you the wrong page.
20 On the bottom, Your Honor, it's 7 of 23. It says 7 of 23.
21 THE COURT: Okay. All right. Go ahead.
22 MR. HOOD: Yes, Your Honor. Under Roman numeral I it
23 says, injury, bruises, burns, fractures, this list is not
24 inclusive, it should be considered suspicious for physical
25 abuse.

1 THE COURT: Let me just read that. I didn't read this
2 yesterday. Okay.
3 MR. HOOD: Yes, Your Honor.
4 THE COURT: Okay. Go ahead.
5 MR. HOOD: And so if Piedmont had a similar type thing,
6 they would have had a duty and obligation to --
7 THE COURT: Well, I'm not worried about Piedmont.
8 MR. HOOD: Oh, I know, but you had asked about was
9 there something about the facts---
10 THE COURT: Yeah, I know.
11 MR. HOOD: ---and that was the one thing I said was
12 whether Piedmont or not -- but getting down to the duty of
13 -- as far as the facts that I think that one thing that was
14 not said -- a couple of things, honestly, Your Honor. This
15 child was put up there on the 5th. There were not just one
16 subdural hematoma, there were two.
17 THE COURT: All right. Let me stop you. Under that
18 Roman numeral, as I read this, it's a protocol beginning
19 with the identification of an injury,---
20 MR. HOOD: Yes, Your Honor.
21 THE COURT: ---leading to obtaining a certain course of
22 history, which leads to and ends with an evaluation
23 protocol; right?
24 MR. HOOD: Yes.
25 THE COURT: Or evaluation and treatment.

1 MR. HOOD: Yes, and then it goes to other things and
2 there are evaluation and treatment for different things and
3 it goes through page 23, which is the algorithm of what you
4 do in regard to if there's a suspicion of abuse going all
5 the way through --
6 THE COURT: All right. Where does -- what is the
7 predicate of Roman numeral I? That is, beyond treatment,
8 what, if anything, does it lead to? What is required?
9 MR. HOOD: It requires a -- when there's a suspicion of
10 child abuse, it requires a reporting to DSS.
11 THE COURT: Okay. All right. What else?
12 MR. HOOD: It requires, when you report to DSS, it also
13 requires that you do a -- complete the McCullough scan form.
14 THE COURT: Well, we've done that. That would be under
15 C.
16 MR. HOOD: Yes. This is a whole protocol, Your Honor.
17 I just gave you the whole protocol.
18 THE COURT: I understand that. What I'm saying is it
19 stops after the treatment.
20 MR. HOOD: It continues -- this is the way it was
21 presented to us from Carolinas Medical Center.
22 THE COURT: Okay. Here we go. C-1 says, refer to CHS
23 policy PR110.03 for policies regarding reporting of
24 juveniles suspected of being abused or neglected. Where is
25 that? Have you got that in here?

1 MR. HOOD: Okay. Hold one second, Your Honor. I'm
2 looking at some of the other experts. Your Honor, I don't
3 know that I've got that in the stuff that I have submitted,
4 because they did actually make the report and there wasn't
5 --
6 THE COURT: Yeah.
7 MR. HOOD: Wait a minute. Here it is, Your Honor.
8 THE COURT: Okay. Where are you?
9 MR. HOOD: Under -- it's page 21 of 23.
10 THE COURT: All right.
11 MR. HOOD: This is the certification of necessity for
12 retention of custody.
13 THE COURT: That's under North -- the thing -- that
14 North Carolina statute.
15 MR. HOOD: No, Your Honor. This is 21 of 23. This is
16 -- it's PR110 --
17 THE COURT: What I'm saying is this necessity for
18 retention of custody refers, essentially, back to this North
19 Carolina general statute that you've got. What is it?
20 78308. It looks like an 8.
21 MR. HOOD: Let me make sure you're looking at what I'm
22 looking at, Your Honor.
23 THE COURT: Nineteen of 23.
24 MR. HOOD: It would be the next --
25 THE COURT: That's actually an Order.

1 MR. HOOD: I think it's the next -- this attachment B,
2 Your Honor.
3 THE COURT: I've got that.
4 MR. HOOD: Yes, Your Honor. I'm sorry.
5 THE COURT: What I'm trying to say is that -- turns out
6 that is a form that seems to me to try to fit into a North
7 Carolina statute that permits retention of custody that Mr.
8 Todd referred to.
9 MR. HOOD: Right.
10 THE COURT: Okay. All right. Go ahead.
11 MR. HOOD: Okay. Your Honor, addressing the duty issue
12 from Mr. Todd,---
13 THE COURT: Yes.
14 MR. HOOD: ---that he had talked about,---
15 THE COURT: Yes.
16 MR. HOOD: ---we've looked and we -- and I've handed up
17 the case, Your Honor, Madison versus Babcock Center. This
18 is the closest thing that we could find to this situation.
19 This case involved a vulnerable adult, who is mentally
20 retarded, and she was put into a private center and it was
21 working with some state agencies, the South Carolina
22 Department of Disabilities and Special Needs, SCDDSN as
23 opposed to DSS, and in that particular case there were
24 absolute duties that were owed by statute, but the South
25 Carolina Supreme Court said, not only that, they said that

1 the Department, and they're talking about DSS here, but it
2 gets into Babcock Center as well, that the center owed a
3 common law duty of care to be necessary to prevent her from
4 harming herself or prevent others from harming her while
5 staying at center and Department had a common law duty to
6 exercise reasonable care and supervising and providing
7 appropriate care and treatment for residents.
8 THE COURT: Let me stop you. That was one of the
9 questions I had yesterday. This -- and I didn't know it was
10 this case. This case involves resident care; right?
11 MR. HOOD: That is correct, Your Honor.
12 THE COURT: And a common-law duty arising just by
13 virtue of the fact that it had, essentially, custody, care
14 and control---
15 MR. HOOD: And it assumed care and custody.
16 THE COURT: ---of the disabled person, mentally-
17 disabled person?
18 MR. HOOD: Right.
19 THE COURT: All right. Go ahead.
20 MR. HOOD: And whether it's mentally disabled, but
21 disabled, as we all know, under statutes in South Carolina,
22 is a disability could be anything from somebody who is
23 mentally retarded or a child who's under the age of
24 eighteen.
25 THE COURT: I agree.

1 MR. HOOD: So you're talking about a common-law duty
2 and Mr. Todd --
3 THE COURT: But doesn't that duty arise out of the fact
4 that this agency had care, custody and control of the
5 person, of this disabled person, as a matter of fact?
6 MR. HOOD: They had care and custody of that particular
7 person, but it -- the way I read this, it said she was --
8 that Babcock Center, and I'm reading directly from the page
9 -- Babcock Center had a special relationship with appellant,
10 because she was a client with special needs and
11 disabilities, admitted for care and treatment at the center.
12 THE COURT: Correct.
13 MR. HOOD: Admitted. Which in this case, our child, he
14 was admitted for care at Carolinas Medical Center and so in
15 this situation --
16 THE COURT: Is there any contention that -- that raises
17 my next question -- the next question I had. Is there any
18 question that that injury to the child occurred -- and I
19 think the answer's obvious. There is no question that
20 injury to the child did not occur while the child was within
21 the care and control of the hospital?
22 MR. HOOD: No, Your Honor, and in fact, I think that
23 brings up even a greater issue. They, actually, were so
24 concerned that there was something going on with these
25 parents, they had a sitter for twenty-four hours a day---

1 THE COURT: Okay.
2 MR. HOOD: ---sit in that room.
3 THE COURT: While the child was a patient?
4 MR. HOOD: While the child was a patient.
5 THE COURT: Okay.
6 MR. HOOD: And that sitter -- to me, they didn't have a
7 duty to do that. They took on that duty to provide that
8 type of care---
9 THE COURT: Correct.
10 MR. HOOD: ---and they assumed that duty.
11 THE COURT: While the child was in their care or
12 custody.
13 MR. HOOD: While that child was in their care or
14 custody, just as they did when they had social work come in
15 and their own algorithm says that you can have a medical
16 discharge, but the difference in this case is just because
17 you're medically discharged doesn't mean that you're
18 socially discharged.
19 The neurosurgeon in this case, Dr. Scott McClanahan,
20 said the child is okay for medical discharge, but it must be
21 discussed with the social worker. So --
22 THE COURT: What is a -- is there a protocol, a
23 separate protocol of the hospital that sort of explains or
24 -- you called it an algorithm -- an algorithm for social
25 discharge?

1 MR. HOOD: The algorithm says when medically clear --
2 THE COURT: Why do we call it an algorithm?
3 MR. HOOD: Because it's --
4 THE COURT: That's got nothing to do with the case.
5 MR. HOOD: It's an attachment F and it's part of that
6 whole thing --
7 THE COURT: I would call it a protocol.
8 MR. HOOD: A protocol. I call it a rule, a safety
9 rule.
10 THE COURT: Where is it?
11 MR. HOOD: It's on page 23 of 23, Your Honor,---
12 THE COURT: Twenty-three of 23.
13 MR. HOOD: ---up under that B-3.
14 THE COURT: All right, sir. Hang on. Okay.
15 MR. HOOD: And it says, when medically cleared, --
16 THE COURT: Okay. Hang on a minute. Oh, they call it
17 an algorithm. Okay. Sorry. Okay. The end of that
18 algorithm is, when medically cleared, do not discharge child
19 until disposition has been determined by medical social
20 worker and DSS.
21 MR. HOOD: And DSS. Not and/or DSS, it's and DSS.
22 THE COURT: I understand.
23 MR. HOOD: And so in this particular situation, our
24 experts that we have, Your Honor, we're not trying to -- the
25 duty of law is yours. That's yours to determine. That's a

1 duty of law.

2 We have -- this notebook that I have given to Your

3 Honor discusses what the -- we're not creating those things.

4 He's elucidating us or -- on as far as what the policies

5 are, the standards in the industry and that kind of thing,

6 but in this particular case -- and Mr. Todd, I'm going to

7 use his brief and in his brief, he himself said that -- and

8 he states -- and he's quoting from that Madison case, a

9 legal duty can be created by statute, and he talked about

10 that, a contractual relationship. This child was up there

11 receiving medical care for which he was billed, status,

12 property interest or some other special circumstance.

13 Everybody understands that if you're under -- if you're

14 admitted for care to a hospital, that they have different

15 things. If you're admitted to a heart unit, you may have

16 cardiology standards of care that would apply.

17 In this case, we have social worker standards of care

18 that apply.

19 THE COURT: Here's what troubles me about this and it's

20 a conflict it seems to me. Other -- well, let's say it this

21 way: the hospital apparently, from what I have reviewed --

22 if there's something here I haven't reviewed, tell me -- I

23 know of no right that the hospital had to deny the parents

24 custody of the child. To have done that, -- laying all

25 these other statutes aside, to have done that would have --

1 as Mr. Todd said, would have amounted to a tort in its own
2 right. So they had -- absent these -- they had an
3 obligation to return the child to the parents when they no
4 longer had a reason to keep the child, a satisfactory reason
5 to keep the child.
6 MR. HOOD: But that's where -- and it's not a duty,
7 it's a violation.
8 THE COURT: And it is -- let me finish. And it's not
9 their -- they have no authority to determine when custody of
10 a child may be denied the parents.
11 MR. HOOD: No. And I'm not saying about custody --
12 THE COURT: It's authority we're talking about here.
13 MR. HOOD: Sir?
14 THE COURT: I'm just talking about authority.
15 MR. HOOD: Well, they could -- and I'll get into it.
16 They could apply, because they're in North Carolina, even
17 though it's a South Carolina case and South Carolina law
18 applies, they've got to utilize the North Carolina law and
19 they could apply to the Court for a twelve to twenty-four
20 hour emergency situation---
21 THE COURT: Max.
22 MR. HOOD: ---and report it to law enforcement -- and
23 report to law enforcement.
24 THE COURT: Okay. The child stayed there for three
25 days for, in quotes, "evaluation", so it exceeded any time

1 imposed by statute when they could have kept the child.
2 MR. HOOD: But the thing is is this is about the safety
3 of a child, Your Honor.
4 THE COURT: Well, I'm talking about -- do you know why
5 that statute exists? They can't keep the child without that
6 statute at all.
7 MR. HOOD: They can't keep the child, but they could
8 apply for that, but this -- and this goes to the duties that
9 they have laid out and he says there's no duty. We've laid
10 out duty after duty after duty with the policies and we've
11 laid out the different -- the social worker standards of
12 care and we're saying that they violated those, because if
13 they had done what they were supposed to do, if the social
14 workers had done what they were supposed to do, there is
15 ample evidence that these were parents that were eighteen
16 years old. These were parents that were at poverty level.
17 They had risk factor after risk factor after risk factor for
18 abusing this particular child and that in -- Kevin Moore,
19 who worked for Charlotte-Mecklenburg Hospital, that's one of
20 our experts. He worked for them.
21 THE COURT: You mean absent of injury, a hospital has a
22 right to keep a child because the parents are poor and
23 uneducated?
24 MR. HOOD: No, but when you have two subdural hematomas
25 and there's no explanation and they can't tell you that

1 there's an explanation and the literature is rife with if
2 you don't have an explanation and you have somebody who's
3 eighteen and you have all these risk factors, one of the
4 most critical elements that you have to have is you have to
5 have an explanation. There was no explanation. They
6 couldn't say, oh, we don't know. Their thing is we don't
7 know how it happened. Well, they also knew --
8 THE COURT: It compares to arson. There's a category
9 of explanations in arson cases that is fire of unknown
10 origin.
11 MR. HOOD: Yes, Your Honor.
12 THE COURT: That's a satisfactory explanation for a
13 fire. We don't know the cause.
14 MR. HOOD: Right.
15 THE COURT: Well, it seems to me that that certainly is
16 much more serious, but --
17 MR. HOOD: But that's criminal, but somebody can sue
18 you civilly.
19 THE COURT: No, that's civil.
20 MR. HOOD: Right, but it can also be criminal and then
21 somebody could sue you for civil,---
22 THE COURT: That's right.
23 MR. HOOD: ---you know, and this is -- this is not a
24 situation -- we're suing civilly.
25 THE COURT: I understand.

1 MR. HOOD: And what I'm saying is that this child, if
2 they had done what they were supposed to do under the duties
3 they owed this child, one, DSS would have had a ton more
4 information, because they would have done what they were
5 supposed to do, laid out by the guy that worked for
6 Carolinas Medical Center, and then it would have allowed DSS
7 -- because you can't always assume that somebody's -- and
8 it's black-letter law that if one doctor does something
9 wrong and it isn't real bad or if somebody's in a car wreck
10 and then the doctor does something and severs their spine,
11 the person that just caused the little back twinge is still
12 responsible for the paraplegia, because the subsequent
13 person -- there's not a break in the intervening -- that's
14 not an intervening negligence. It's foreseeable that
15 somebody can do something that's wrong and in this
16 particular case you have somebody who had a duty, they
17 breached that duty --
18 THE COURT: Well, you're assuming a duty.
19 MR. HOOD: No, Your Honor. We've laid out the duties
20 that they had in this --
21 THE COURT: What are they?
22 MR. HOOD: Sir?
23 THE COURT: What are they?
24 MR. HOOD: They have a duty --
25 THE COURT: Let me say it this way: if you brought

1 your child to my house to play with my kid and I saw your
2 child had bruises about their arms and legs or on their head
3 and the child was kind of woozy, at common law, I have no
4 duty to report that, to do anything. I have no duty to do
5 anything.
6 The duties that have been imposed in this area, which
7 is certainly critical, are duties that are imposed at law,
8 typically, by statute and, in some cases, by case law.
9 Duties are not presumed.
10 If you brought your child to my house and I saw that
11 the child was injured -- to play with my -- or your
12 grandchild and my grandchild -- let's put it that way.
13 MR. HOOD: Right.
14 THE COURT: -- and I saw that the child was injured, do
15 I have a duty to report it? Do I have a duty to do
16 anything? I think that answer's no at common law.
17 The duties that are imposed are duties that are imposed
18 upon people who run a -- who have the ability to -- I guess
19 we've imposed them because we want to impose extra care, to
20 see to the care of protecting children from these kind of
21 things, which in this case happened, but absent that,
22 there's no duty at all. The duty -- and you haven't shown
23 me a duty---
24 MR. HOOD: Your Honor, --
25 THE COURT: ---in these policies that exceeds that.

1 MR. HOOD: I'm not saying that it exceeds it. We're
2 talking about a duty that's separate and independent from a
3 statutory duty.
4 THE COURT: It would be a new duty, in my opinion,
5 under the case law.
6 MR. HOOD: How would it be a new duty if --
7 THE COURT: Because these people did not have care,
8 custody or control of the child, had no right to keep the
9 child.
10 MR. HOOD: But it was admitted, just like it was in the
11 lady that was admitted to the Babcock Center.
12 THE COURT: And you've told me that they exercised
13 extreme care while the child was admitted and kept.
14 MR. HOOD: No, Your Honor. I've laid out that they did
15 not exercise extreme care, not from a social work
16 perspective and that's a violation of a duty.
17 THE COURT: They -- you told me they had a sitter for
18 the child twenty-four/seven.
19 MR. HOOD: Yes, but that is not the social work
20 standard of care we've laid out -- Kevin Moore and we had
21 George Savarese who've laid these specific violations---
22 THE COURT: I will --
23 MR. HOOD: ---of the standard of care.
24 THE COURT: Listen to me.
25 MR. HOOD: Yes, Your Honor.

1 THE COURT: I will grant you that they had a duty while
2 they had the care, custody and control of the child when it
3 was there for evaluation and treatment. They had -- beyond
4 the statutory duty to report, so far as I know, as far as I
5 know, they had no duty to look after the care of the child,
6 which is really what we're talking about, bottom line, after
7 the child was taken from them or dismissed by them. The
8 only question becomes did they comply with the statutory
9 duty in respect to protecting the child as best they could?
10 MR. HOOD: Okay. And just, Your Honor, the -- one of
11 the standards that we're saying that applies in this case --
12 of duty that applies in this case,---
13 THE COURT: Yes, sir.
14 MR. HOOD: ---is a JCAHO standard for provision of
15 care, treatment and --
16 THE COURT: What's JCAHO?
17 MR. HOOD: I'm sorry?
18 THE COURT: JCAHO?
19 MR. HOOD: Yes, Your Honor.
20 THE COURT: What is that?
21 MR. HOOD: It's the Joint Commission of Accreditation
22 of Hospital Organizations.
23 THE COURT: Oh.
24 MR. HOOD: And it requires victims of abuse be
25 assessed, specific criteria be developed for child abuse

1 cases and appropriate staff is educated on how to address
2 abuse cases.
3 In our -- there's also, Your Honor, we contend, a duty
4 while the child is there under the care of Carolinas Medical
5 Center. There's a duty to --
6 THE COURT: I assume these parents signed a permission
7 -- a written permission for the treatment for the child; did
8 they not?
9 MR. HOOD: Sure, but we say there's a need to access,
10 communicate, intervene and document in regard to the social
11 work aspect of this particular child.
12 THE COURT: Why do you say that?
13 MR. HOOD: Sir?
14 THE COURT: Is there a South Carolina case that holds
15 that?
16 MR. HOOD: There's a South Carolina case that says they
17 owe a general duty of care.
18 THE COURT: That's the Babcock case.
19 MR. HOOD: Yes, Your Honor.
20 THE COURT: Well, that person was in the care, custody
21 and control of Babcock -- not Bab- -- the Department and the
22 injuries happened while that person was in the care, custody
23 and control of the institution.
24 MR. HOOD: Right, but the thing is, Your Honor, the --
25 whether the injury occurred while they were in the care,

1 custody and control should be irrelevant if the duty applied
2 while they're within the care, custody and control.
3 THE COURT: There we disagree.
4 MR. HOOD: Why is that, Your Honor? Because negligence
5 is --
6 THE COURT: I don't have to explain to you why, I just
7 don't think it's the law.
8 MR. HOOD: Well, I think that the law is negligence is
9 duty -- breach of duty and damages.
10 THE COURT: That's correct.
11 MR. HOOD: And it doesn't have to be within twelve
12 hours, it could be something that is -- could be thirty days
13 apart and that gets into causation, whether there's -- you
14 know, but for causation or foreseeability.
15 THE COURT: They complied -- the only thing that they
16 had was that statutory duty unless -- except when the child
17 was in the care, custody and control of the hospital.
18 MR. HOOD: Okay.
19 THE COURT: Okay. It appears to me -- and, hopefully,
20 it appears that I've read this material. It appears to me
21 that they -- the only additional duty was a duty to report
22 to try to prevent injury to the child after they had care,
23 custody or control of the child. It appears to me they
24 complied with that duty---
25 MR. HOOD: I would --

1 THE COURT: ---and they associated the very agency that
2 has to deal with it.
3 MR. HOOD: I agree that they complied with their duty
4 to report. What I don't agree with is that they -- there
5 was a duty -- and while the duty of care was -- they had
6 this duty of care while the child was in their custody and
7 control. The social worker --
8 THE COURT: To see that the child was not injured while
9 in their care, custody or control.
10 MR. HOOD: Not to see whether the child was injured,
11 but to do what was supposed to be done under a general duty
12 of care, which is assess, document, intervene, the things
13 that we've talked about and, in fact, Your Honor, you have a
14 situation where one of the things -- another case that they
15 have cited, and this is my case, is the Faile case. It says
16 -- and Mr. Todd cited this in his brief. There's the Faile
17 case, Your Honor.
18 Under the Faile case, it says that under South Carolina
19 law, there's no general duty to control the conduct of
20 another or the one of a third person or potential victim of
21 danger and then it has -- it recites the statement of 314
22 and then it gives five exceptions to that. It says, we
23 recognize five exceptions: where the defendant has a
24 special relationship to the victim. That didn't occur in
25 this particular case, but where the decedent has a special

1 relationship to the injurer, and in that particular case, if
2 you go to that specific footnote, --
3 THE COURT: Which is where? Which footnote? I don't
4 see any footnotes.
5 MR. HOOD: I'm sorry, Your Honor. It's right here.
6 They put them right in the middle of the page sometimes.
7 THE COURT: Which page are you on?
8 MR. HOOD: I'm sorry, Your Honor. Page thirteen.
9 THE COURT: All right.
10 MR. HOOD: One, it says, there's no duty to control the
11 conduct of a third person to prevent him, unless a special
12 relationship exists between the actor and the other, which
13 gives the other a right to protection. When a person is in
14 a position to monitor, supervise and control a person's
15 conduct, the special relationship between the defendant and
16 the dangerous person may trigger a common-law duty to warn
17 potential victims of the danger. That isn't it, but what
18 you have is where the defendant voluntarily under case of
19 duty.
20 In this particular case, they had social workers that
21 came into the room, did a very specious -- they, basically,
22 said, what's your name, how are you doing and they did not
23 do what they were supposed to do. They undertook the duty
24 to perform that social work role, but they didn't do it in a
25 responsible manner or in a manner that was supposed to be

1 done and under the Faile case, and it's just black-letter
2 law --
3 THE COURT: Wasn't DSS doing that?
4 MR. HOOD: No. It was also -- it was both, Your Honor.
5 It's a joint responsibility. DSS was doing it and we've
6 sued DSS for that, but there's a joint responsibility,
7 because it was also the hospital that was doing it.
8 THE COURT: Where is the protocol or algorithm for what
9 a social worker's supposed to do?
10 MR. HOOD: We have -- Your Honor, we have two. We have
11 the protocol that says that there's not supposed to be a
12 discharge until, basically, social work and --
13 THE COURT: DSS.
14 MR. HOOD: -- and DSS agree.
15 THE COURT: And apparently they did.
16 MR. HOOD: Well, the thing is, though, if they did and
17 they did it wrong, then there is a duty and we're saying
18 that they violated that duty. That's what we're saying, is
19 that they violated that duty, because they owned it jointly.
20 THE COURT: Violated it how?
21 MR. HOOD: Because they allowed this child to be
22 discharged and they couldn't say -- Your Honor, here's a
23 child with two subdural hematomas and they say -- they,
24 basically, throw up their hands. We don't know whether it
25 is or it's not, but you all have these risk factors and

1 everything else and the doctor herself said it's a coin
2 flip.
3 THE COURT: And they disclosed all that?
4 MR. HOOD: They disclosed that the child was medically
5 stable to be discharged, but medical discharge is different
6 than social discharge. There -- you have to -- in a case of
7 child abuse, the policy and procedure and also the joint
8 commission and also the social worker, the standards of care
9 in the industry from -- that are applicable in this case by
10 the National Association of Social Workers, they all say
11 that you have to do a proper assessment. There was not a
12 proper assessment done in this particular case. If there
13 was a proper assessment done, you would have been able to
14 give a lot more information, because, honestly, -- and no
15 offense to DSS, but we've alleged that they were grossly
16 negligent.
17 THE COURT: All right. The only thing that I want to
18 hear anymore about is from Mr. Todd about this social worker
19 business.
20 MR. HOOD: Okay.
21 THE COURT: I understand your position.
22 MR. HOOD: Yes, Your Honor. Thank you.
23 MR. TODD: Your Honor, the social worker in this case,
24 called DSS, reported --
25 THE COURT: Tell me who the social worker is?

1 MR. TODD: The social worker was Laura Neumark.
2 THE COURT: And she works for CMC?
3 MR. TODD: Yes, sir.
4 THE COURT: All right.
5 MR. TODD: And she would take information from the
6 doctors, provide it to DSS.
7 THE COURT: Yeah.
8 MR. TODD: She reported to DSS this child -- the
9 doctors have not been able to definitively rule in or rule
10 out child abuse.
11 THE COURT: What else does her job description require
12 her to do with respect to a child where an evaluation like
13 that is done?
14 MR. TODD: Well, she's supposed to get the information
15 from the doctors and provide it to CMC.
16 THE COURT: What else?
17 MR. TODD: Your Honor, that is --
18 THE COURT: What about dealing with the child?
19 MR. TODD: They did take a history from the child.
20 They did observe the child---
21 THE COURT: Who did?
22 MR. TODD: ---in the room with the parents. Social
23 workers, doctors, nurses.
24 THE COURT: All the above?
25 MR. TODD: Well, your Honor, they were in the room with

1 the -- they were in there with the child.
2 THE COURT: My question is -- my question is what does
3 -- let me say it this way: is there a hospital policy that
4 defines what it is a social worker is supposed to do in such
5 a case where there is no -- where there's no medical finding
6 that there's been child abuse?
7 MR. TODD: No, sir. He points to the algorithm, policy
8 or procedure, whatever it is, where the social worker is
9 supposed to clear a discharge --
10 THE COURT: Here's what it says, when medically
11 cleared, do not discharge child until disposition has been
12 determined by medical social worker and DSS.
13 MR. TODD: Well, the social worker, when she was
14 deposed, said it's my duty, it's my responsibility to
15 contact DSS and find out what kind of discharge provisions
16 they want us to do. You know, it gets back to, I think you
17 said, they have no authority to detain this child. It's set
18 forth in the statute and --
19 THE COURT: So if she disagreed -- if the social worker
20 disagreed with DSS, the hospital would be in the position of
21 trumping DSS by keeping the child, which---
22 MR. TODD: We don't --
23 THE COURT: ---in other words, if she says, I disagree
24 with them and it says determined by medical social worker
25 and DSS, this social worker would be, essentially, trumping

1 DSS's opinion and advising the hospital to keep the child?
2 MR. TODD: I guess if that were the situation, then
3 we'd have to -- they still have no authority to detain the
4 child, absent authority for some state agency or court.
5 THE COURT: Or in this case, a North Carolina statute.
6 MR. TODD: For twelve hours, Your Honor.
7 THE COURT: Yes.
8 MR. TODD: And then the immunity statute that has not
9 been addressed and the immunity statute is clear, if you
10 participate in the investigation, which is what was done in
11 this case, and obviously there's a policy, they do want
12 persons who report to participate in the investigation and
13 there's immunity for that, absent bad faith, which, in this
14 case, there's no allegation of bad faith. There's no
15 pleading, there's no proof. So there's no duty and there is
16 immunity.
17 THE COURT: So if DSS said -- all right. Let me ask
18 Mr. -- Mr. Hood?
19 MR. HOOD: Yes, Your Honor.
20 THE COURT: If DSS said, release the child and the
21 social worker said, do not release the child, would not the
22 hospital be in violation of the law by keeping the child?
23 MR. HOOD: No, Your Honor. They could apply to the
24 courts to hold the child and that would trigger an automatic
25 reporting to law enforcement and that would start a whole

1 different thing in regard to --
2 THE COURT: Well, DSS reported it to law enforcement;
3 did they not?
4 MR. HOOD: Not on the 8th, they didn't. They didn't
5 report it to law enforcement until the 17th.
6 THE COURT: I thought somebody said that a few minutes
7 ago.
8 MR. HOOD: No and, in fact, when the -- we've got the
9 recording of the call from law enforcement and law
10 enforcement, what they said was, you've got to be kidding
11 me. You're telling me now, on the 17th, with a child who
12 has two subdural hematomas and we're just getting this now
13 and this happened eleven days ago? And, Your Honor, I want
14 to hand this up. Here's that policy. I just wanted Your
15 Honor to see that. There's the policy and it also says that
16 there has to be a safety plan on the chart in writing.
17 THE COURT: If applicable.
18 MR. HOOD: If applicable. In this case it was
19 applicable.
20 THE COURT: They didn't know it was applicable.
21 MR. HOOD: Yeah, they knew it was applicable. They
22 admitted that it was supposed to be on the safety -- it was
23 supposed to be on the chart.
24 THE COURT: Well, what was the plan?
25 MR. HOOD: We've gotten different testimony about that,

1 Your Honor, discharge to the parents. Your Honor, here's a
2 --
3 THE COURT: Wait. Let me just read one thing.
4 MR. HOOD: Yes, Your Honor. I'm sorry.
5 THE COURT: So what we're getting down to is is
6 whether, as a matter of law, the hospital had a duty to
7 retain custody of the child?
8 MR. HOOD: Or, Your Honor, here's this from the doctor
9 on 12/7/08 --
10 THE COURT: Am I right or wrong?
11 MR. HOOD: That says that's it okay to discharge under
12 supervision.
13 THE COURT: Was not DSS supervising?
14 MR. HOOD: Your Honor, they didn't even go see the
15 family, I think, until probably the 17th or the 21st.
16 THE COURT: Well, the hospital doesn't know what DSS
17 will do. They know DSS is a state agency that's supposed to
18 be looking after children. DSS could be negligent apart
19 from the hospital.
20 MR. HOOD: Yes, or in conjunction with the hospital and
21 it certainly -- it isn't on the chart. We can't find it on
22 the chart anywhere.
23 THE COURT: So the question is whether there's a
24 genuine -- this is a summary judgment motion. The question
25 is whether there's a genuine issue of fact concerning

1 whether DSS failed -- I'm sorry -- whether CMC failed to
2 retain custody of the child---
3 MR. HOOD: Or --
4 THE COURT: ---after, A, they couldn't medically say
5 that the child had been abused and, B, DSS had cleared them
6 to release the child.
7 MR. HOOD: I think there's more than that, Your Honor.
8 I think there's also a duty to assess and they didn't do
9 that properly. I think that that is in there, too, but if
10 we even take Your Honor -- if we took what Your Honor said,
11 we've presented affidavits, not about the duty, but about --
12 we've produced a scintilla of evidence in that regard.
13 THE COURT: What is that?
14 MR. HOOD: Whether there was a violation of that duty
15 or not.
16 THE COURT: But that presupposes a duty.
17 MR. HOOD: No, no, Your Honor. I'm just answering your
18 question. You said -- your question was --
19 THE COURT: What is the scintilla of evidence that they
20 violated the duty?
21 MR. HOOD: We've presented affidavits with -- one is
22 seven pages, one is thirty pages, talking about the duty
23 that they violated in this particular case.
24 THE COURT: Okay. I've heard enough. I'm going to
25 grant the motion. I believe that there is a genuine issue

1 of fact whether CMC fulfilled its duty. I construct that
2 from the proposition that they complied with the law. They
3 were advised by the appropriate state agency that the child
4 should be released and that there's no -- certainly no issue
5 of fact that they exercised care under the Babcock case for
6 the child while the child was in the custody of the
7 hospital.
8 What we're talking about is the duty to retain a child
9 when they had no legal right and could not support what they
10 were doing medically. So I'm going to grant the motion.
11 Mr. Todd, you need to email me, in Word format, a
12 proposed Order.
13 MR. TODD: Yes, sir.
14 MR. HOOD: Your Honor, just for the purpose of --
15 THE COURT: Put anything on the record you want to.
16 MR. HOOD: Your Honor, as far as we -- of course, we'll
17 do the 59(e) thing after that, but what would be the --
18 because this is so intertwined with DSS and everything else,
19 from an interlocutory standpoint, would it be you or Judge
20 Hayes that we would be applying -- making a motion for
21 interlocutory appeal in this case?
22 THE COURT: I supposed it would be Judge Hayes.
23 MR. HOOD: Okay.
24 THE COURT: The 59(e) would come here. I don't know.
25 Ask somebody. Look at the rule. I don't know the answer to

1 that question off the top of my head.
2 MR. HOOD: Okay. Thank you.
3 MR. TODD: Your Honor, just one housekeeping matter.
4 We had -- Mr. Hood and I talked about -- we presented and
5 I've referenced a number of depositions, Mr. Hood presented
6 voluminous materials. What we were going to do is, if that
7 motion were granted, file those with the clerk at that time.
8 So do we do that here?
9 THE COURT: No, not here. You do that down the street.
10 MR. TODD: Okay. Thank you.
11 THE COURT: Where there is still no courthouse.
12 MR. TODD: Yes.
13 THE COURT: Yeah. And what all are you going to file
14 now?
15 MR. TODD: The depositions that we've referenced. I
16 mean, I think they set for the facts and --
17 THE COURT: I need to file all of this, 'cause I'm
18 going to eventually send all this back.
19 MR. TODD: Okay. I think that's Mr. Hood's.
20 THE COURT: It is.
21 MR. HOOD: We can just jointly go down and file --
22 MR. TODD: We can just go and get that done.
23 THE COURT: I need to -- I'm going to keep the basic
24 file, 'cause I got to -- if I have to tweak, you know, tweak
25 the Order as I see fit. I'm going to keep this. I suppose

1 I need to keep this.
2 MR. TODD: We'll work together and just file what we've
3 agreed upon and --
4 THE COURT: Especially -- well, if he's going to do a
5 59(e), I need to keep it anyway, so -- all right. Anything
6 else?
7 MR. TODD: That's all, Your Honor.
8 THE COURT: Thank you.
9 MR. HOOD: Your Honor, very -- just for the purposes of
10 the record, to keep something for 50(E), we would have said
11 that in regard to the immunity issue, that that only goes to
12 the reporting and for somebody getting sued for liable
13 defamation and that kind of thing and there's a case called
14 Williams versus Babcock, where they address that and if Your
15 Honor ruled on that, then that's something that was raised
16 and that way -- or we can address it on a --
17 THE COURT: So what you're saying is does immunity mean
18 immunity from violation of a common-law duty, essentially?
19 Separate and apart from a common-law or statutory duty?
20 MR. HOOD: Yes.
21 THE COURT: To the extent -- do you agree with that,
22 Mr. Todd?
23 MR. TODD: I got distracted, Your Honor.
24 THE COURT: Well, I understand. Let me say it this
25 way: to the extent the -- yeah. We're not through. I'm

1 sorry, Randy. I didn't -- we didn't address that properly.
2 The immunity, as I understood Mr. Todd's argument, is
3 based upon 63-7-390, which is premised on 67- -- I'm sorry
4 -- 63-7-310, all of which has to do with a duty to report
5 and upon reporting, gives immunity from civil liability as
6 well as criminal, but civil liability.
7 MR. HOOD: For the reporting function?
8 THE COURT: Excuse me?
9 MR. HOOD: For the reporting function, Your Honor?
10 THE COURT: Yes.
11 MR. HOOD: Yes, sir.
12 THE COURT: Well, no, no, no. Let me complete -- for
13 the reporting agency and that immunity extends to full
14 disclosure by the person of facts which gave the person
15 reason to believe that the child's physical or mental health
16 or welfare had been or might be adversely affected by abuse
17 or neglect.
18 My view of that is that construing that statute in
19 context and the proper parameters applies to immunity for
20 reporting only. I do not believe that one could claim
21 immunity from civil liability for a violation of a duty
22 separate and apart by claiming under the statute. Does that
23 answer the question?
24 MR. HOOD: Yes, Your Honor. Thank you.
25 THE COURT: So that, in essence, Mr. Hood's argument

1 about the other duties and whatnot, I believe would be
2 unaffected by 63-7-390 by a narrow reading of that statute
3 as it's written. Does that answer your question?
4 MR. HOOD: Thank you, Your Honor. Yes.
5 MR. TODD: Your Honor, it wasn't -- I know that it
6 wasn't set out,---
7 THE COURT: Yes.
8 MR. HOOD: ---but anyway,---
9 THE COURT: Well, you didn't win that one.
10 MR. TODD: I know, but I will address it. The statute
11 says a person required or permitted to report,---
12 THE COURT: Yeah.
13 MR. TODD: ---pursuant to the reporting statute,---
14 THE COURT: Yeah.
15 MR. TODD: ---or who participates in an investigation.
16 So a lot of Mr. Hood's argument goes to the participation of
17 the social worker in the investigation, participating with
18 DHEC. So when you read in the or who participates, that
19 brings this immunity statute into play and makes it
20 applicable in this case.
21 THE COURT: Unless not acting in good faith?
22 MR. TODD: Yes, sir.
23 THE COURT: What about that, Mr. Hood?
24 MR. HOOD: Your Honor, this is all about the reporting
25 function. If they had to do an investigation or participate

1 in something before making their report and whatever they
2 had to do to make a report, I agree they're entitled -- for
3 everything that had to with the reporting, they're entitled
4 to immunity for that, but this is all post-reporting conduct
5 that we're talking about here.
6 THE COURT: No. It says investigation.
7 MR. HOOD: Yes, Your Honor, but it's also talking about
8 in the reporting function and it's under the reporting part
9 of that --
10 THE COURT: No. I disagree with that. It says, a
11 person who is required to report or who participates in an
12 investigation.
13 MR. HOOD: In an investigation to make the report, Your
14 Honor. They're just --
15 THE COURT: No, it doesn't say that.
16 MR. HOOD: Okay. Your Honor, I'll show you a case.
17 It's called Williams versus Babcock. Let me find it.
18 THE COURT: I think I can save you some time.
19 MR. HOOD: Yes, Your Honor.
20 THE COURT: I think, in any event, your claim is that
21 the investigation would have been made not in good faith to
22 the extent, I mean, that the social worker what she was
23 absolutely, according to your side of the story, your side
24 of the case, absolutely demanded to do under proper facts?
25 MR. HOOD: That is correct, Your Honor. Good faith and

1 violates the standard care in doing what she was supposed to
2 do, Your Honor.
3 THE COURT: But this -- that statute protects people
4 who are not -- are -- upon which -- there is no imposition
5 of a duty to report, I think. So in other words, a private
6 social worker, not an employee of the hospital who had no
7 duty -- and if we assume that the hospital had called in a
8 private social worker, somebody in private practice or a
9 psychologist, whatever, and had them do an evaluation and
10 that person made the report, a written summary of their
11 evaluation, not a report of child abuse, as required by
12 statute, I believe that person is also protected, because
13 that person has made defamatory remarks, if the remarks are
14 not true. Actually, it's libelous, because it's a written
15 report.
16 MR. HOOD: And I think that's what that Williams case
17 says is it was a case where somebody went in, they had said
18 something and then the social worker had given it to a
19 psychologist to review, the psychologist had done an
20 investigation or had done a counseling session with somebody
21 who is a vulnerable adult, somebody mentally retarded, and
22 then the social worker then spoke with the psychologist who
23 had done that and so the social worker and psychologist had
24 decided, okay, it needs to be reported. Social worker makes
25 the report, she gets sued for liable and defamation. The

1 reporting only. Hold on a minute.
2 Let me just say it this way: I don't think the statute
3 -- I'm going to go back to what I said originally. I don't
4 believe the statute shields the hospital or anybody else for
5 other duties they might have had apart from the reporting
6 process.
7 I'm going to deny summary judgment based on the
8 immunity statute. Well, there's -- are you claiming there's
9 any liability under the statute?
10 MR. HOOD: No, Your Honor.
11 THE COURT: Okay. We'll leave it there.
12 MR. TODD: Yes, sir.
13 THE COURT: Thank you.
14 MR. TODD: I will send the Order to Mr. Hood for review
15 before I send it --
16 THE COURT: As he will tell you, I'm going to tweak it
17 to suit what I want it to say.
18 MR. TODD: Send it to you and Mr. Hood at the same
19 time?
20 THE COURT: Send it simultaneously. Yeah.
21 MR. TODD: We'll do it.
22 THE COURT: Okay. Thank y'all.
23 MR. TODD: Thank you.
24 MR. HOOD: Thank you, Your Honor.
25 (END OF REQUESTED TRANSCRIPT)

STATE OF SOUTH CAROLINA)
) C E R T I F I C A T E
COUNTY OF YORK)

I, the undersigned Shannon E. McGilberry, official Court Reporter for the Sixteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete transcript of the record of all proceedings had and evidence introduced in the hearing of the captioned case, relative to appeal, in the Civil Court for York County, South Carolina, on the 18th day of April, 2013.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

In witness whereof, I have hereunto subscribed my name, this 30th day of April, 2013.

Shannon E. McGilberry

My Commission Expires:
April 16, 2017

State of South Carolina)
)
County of York)

Elizabeth Hope Rainey,) 11-CP-46-04508
as the appointed)
Guardian ad Litem to)
[redacted], a minor,)
) Transcript
Plaintiff,)
) of
vs.)
) Hearing
Charlotte-Mecklenburg)
Hospital Authority d/b/a)
Carolinas Medical Center,)
South Carolina Department)
of Social Services, Bruce)
Bryant, as the)
Constitutional Office of)
York County,)
)
Defendants.)

The within hearing, taken before Susan A. Wyant, a notary public in and for the State of South Carolina, commencing at the hour of 9:32 a.m., Wednesday, August 14, 2013, at the office of York County - Master in Equity's office, 1 North Congress Street, York, South Carolina.

Reported by
Susan A. Wyant

APPEARANCES

The Court: The Honorable S. Jackson Kimball, III
York County - Master in Equity's office
1 North Congress Street
York, South Carolina 29745

For the Plaintiff: Deborah G. Casey, Esq.
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732

For the Defendant South Carolina Department of Social Services: Patrick J. Frawley, Esq.
Davis Frawley, LLC
140 East Main Street
Lexington, South Carolina 29072

For the Defendant Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center:
Monteith P. Todd, Esq.
Sowell Gray Stepp & Laffitte, LLC
1310 Gadsden Street
Columbia, South Carolina 29201

INDEX

Proceedings 3

EXHIBITS

No exhibits were marked during this hearing.

1 P R O C E E D I N G S
2 MS. CASEY: If it may please The Court, again, my name
3 is Debra Casey. I am here on behalf of the
4 plaintiff with respect to this motion to reconsider
5 your prior order. Your Honor, the -- upon review
6 of the transcript and some other -- and the other
7 materials that were covered in the prior motion for
8 summary judgment, the plaintiff believes that The
9 Court previously erred in its granting of summary
10 judgment and that there is a reason to reconsider
11 and reverse or amend the prior ruling.
12 And if -- do I need -- or would you like for
13 me just to refresh the facts, Your Honor, with
14 respect to the case, or are you still --
15 THE COURT: I don't think so. I -- I'm -- this young --
16 young child was presented at -- at the Levine
17 Children's Hospital in -- with an injury. They
18 determined that he had a subdural hematoma. They
19 notified the Department of Social Services. They
20 did a further evaluation of the child. They held
21 the child for, I think, three or four days before
22 releasing -- releasing the child, medically, back
23 to his parents. And in conjunction with that, DSS
24 advised them to release the child back to the
25 parents.

1 MS. CASEY: Your Honor, I believe that is a -- a
2 statement of the facts, but -- but I -- we
3 believe --
4 THE COURT: Add --
5 MS. CASEY: -- that --
6 THE COURT: -- anything you want to.
7 MS. CASEY: Well, we believe there is more -- more to
8 the -- more to the story, if you will, on this.
9 THE COURT: I know you do.
10 MS. CASEY: I believe there was some question with
11 respect to the initial transfer of [redacted] to the
12 Levines Children Hospital from Piedmont. And the
13 reason he was transferred is that they had done a
14 lumbar puncture and he was found to have some blood
15 in the spinal fluid.
16 THE COURT: Uh-huh.
17 MS. CASEY: And that is an abnormal finding for a child
18 or -- or an adult, and as a result of that, he was
19 transferred to this -- this more specialized
20 facility. And once he was admitted to Levine,
21 there was an additional workup done that did reveal
22 that he had these subdural hematomas. That raised
23 an index of suspicion of child abuse with the
24 caregivers at Levine Children's Hospital, which set
25 in motion a set of -- of activities pursuant to

1 their policies and pursuant to the -- the South
2 Carolina statute.
3 And the defendants in the case would have you
4 believe that the duty to report was the only duty
5 that the hospital had in this particular case and
6 they did comply with that. I believe, when Mr.
7 Hood was here, we -- we agreed that they -- that
8 "they," being Levine, did comply with the duty to
9 report to the DSS, and a DSS representative was
10 sent to the -- to the hospital to talk to the
11 parents and -- and health care providers.
12 But in this particular case, I think what you
13 have is you have a patient who's voluntarily
14 admitted to a health care facility, and by virtue
15 of that voluntary admission as a patient, that
16 gives rise to a legal duty to treat that patient
17 with reasonable care.
18 Now, that reasonable care sort of takes a --
19 two different prongs. The first is the medical
20 care, where we're doing the evaluations, the scans,
21 the blood work, and things of that nature. But in
22 this case, Levines Children's Hospital --
23 THE COURT: Now, there's never been any issue raised
24 concerning the medical care.
25 MS. CASEY: No, Your Honor, there is no -- no issue

1 raised with regard --
2 THE COURT: All right.
3 MS. CASEY: -- to the medical care that was provided by
4 the -- the hospital --
5 THE COURT: All right.
6 MS. CASEY: -- and the -- the physicians.
7 But the -- the -- the example here is that
8 there -- it's -- there are really two components to
9 this: the medical care and then the psychosocial
10 assessment or the social work assessments that were
11 done.
12 [redacted] was admitted voluntarily. The parents
13 signed a consent that they would allow him to stay
14 in the hospital and would not discharge him until a
15 physician said that he was medically ready to be
16 discharged.
17 THE COURT: Nobody's ever raised that before.
18 MS. CASEY: That -- it -- it -- there is a consent in
19 the record that -- that they signed, and they were
20 asked to sign.
21 THE COURT: Was it presented to me before?
22 MS. CASEY: I believe it was in the medical records,
23 Your Honor, but I -- I do not have that --
24 THE COURT: All right.
25 MS. CASEY: -- consent with --

1 THE COURT: That's all right.
2 MS. CASEY: -- me.
3 THE COURT: Go ahead.
4 MS. CASEY: I -- I don't believe that Mr. Todd will
5 dispute that, that -- that they were asked to do
6 that and --
7 THE COURT: Well, does --
8 MS. CASEY: -- and that --
9 THE COURT: -- it add anything to the argument? I mean,
10 we know that the child was -- was treated and
11 medically -- ultimately, medically released at --
12 MS. CASEY: Well, I think it adds something in the -- to
13 the degree that it --
14 THE COURT: You're trying to say that the consent was a
15 consent for the -- for the hospital to -- to retain
16 the child against the parents' wishes?
17 MS. CASEY: No, Your Honor. I'm not saying that at all,
18 because I don't believe today's argument is in
19 respect to the -- the release of the child. This
20 goes back to before the -- the release was even
21 considered. And this was a question that The Court
22 had previously as to whether there was a duty owed
23 to [redacted], other than the duty to report. And it's
24 our contention and our position, and I believe that
25 the -- the facts in the case support that he was a

1 patient at the hospital, and there was a special
2 relationship between this hospital and this -- this
3 patient, which gives rise to a duty to provide
4 appropriate care and treatment. And part of that
5 appropriate care and treatment is the psychosocial
6 evaluation.
7 The hospital took it upon themselves to assign
8 a social worker, or several social workers, from
9 the maltreatment care team who have special
10 training in identifying the child abuse, or
11 potential child abuse, which that suspicion had
12 already been raised.
13 Ms. Newmark testified in her deposition that
14 she had a number of years of experience and that
15 she was trained to recognize child abuse. So she
16 has it -- has that special training and knowledge.
17 The hospital voluntarily assigned these folks, as
18 part of their program and their standards of care,
19 to do a psychosocial assessment.
20 Our -- our --
21 THE COURT: Was that assessment completed?
22 MS. CASEY: That is the core question. There is a --
23 THE COURT: No. It's --
24 MS. CASEY: Whether or not it --
25 THE COURT: -- it's my question. What -- was it -- what

1 -- factually, was the assessment completed?
2 MS. CASEY: Her assessment was performed. It is our
3 contention that it was not performed and it was not
4 completed in a manner that comported with the
5 standard --
6 THE COURT: Did it --
7 MS. CASEY: -- of care.
8 THE COURT: -- result in a -- in a recommendation or a
9 conclusion?
10 MS. CASEY: It did not. It did not result in any
11 conclusions. Her -- her role, as she says in her
12 deposition, was to simply --
13 THE COURT: How about --
14 MS. CASEY: -- report --
15 THE COURT: -- findings?
16 Ms. CASEY: Her findings were that the family had some
17 risk factors, that they -- that the parents were
18 young, not married, and that the findings were that
19 -- that, based on what the -- the hospital
20 physician said, that the child could be discharged
21 when medically stable, but there needed to be a
22 coordination between the social worker and the DSS
23 representative for --
24 THE COURT: And there was.
25 MS. CASEY: I don't think that -- I think that's a

1 question of fact that we do not have the answer to,
2 Your Honor.
3 THE COURT: Well, the -- the -- the D -- is -- it's --
4 it is not a question of fact whether DSS performed
5 its own evaluation and either ordered or -- I've
6 got a -- I'm not sure that's the right word -- but
7 directed the release of the child or authorized the
8 release of the child to the parents.
9 MS. CASEY: Your Honor, that authorization was premised
10 upon consultation with the -- the employees of the
11 hospital with respect to findings. And that is the
12 crux of the case in terms of this issue, is that it
13 is the plaintiff's contention that the findings
14 were not significantly -- or the -- the facts and
15 circumstances surrounding the psychosocial
16 background of this family and the -- and the child
17 was not sufficiently explored by the hospital to
18 provide enough information to the DSS in order for
19 DSS to make an informed decision about whether or
20 not this child should have been released to the
21 parents.
22 THE COURT: Well, let me ask you this. And here's
23 what's -- what's always -- let's -- let's assume
24 that -- that the hospital and -- and the social
25 worker -- the social worker rendered an opinion or

1 was of the opinion that the child had been abused,
2 that the injury -- that the -- that is, that the
3 injury was a result of -- of child abuse, but that
4 DSS disagreed and authorized -- authorized and
5 directed the release of the child to -- to the
6 parents. Are you saying, then, that -- that --
7 that the hospital had a duty to retain the child
8 anyway?
9 MS. CASEY: Well, I think the hospital had a duty to set
10 forth some -- or to set in action some -- some
11 action that could have either called in the
12 authorities -- I -- I don't want --
13 THE COURT: The authorities were called in.
14 MS. CASEY: Well, the --
15 THE COURT: That's why the sheriff's department was made
16 a party to this case.
17 MS. CASEY: Well, the -- the authorities were not called
18 in by the hospital.
19 THE COURT: No.
20 MS. CASEY: They were called in by DSS --
21 THE COURT: By DSS.
22 MS. CASEY: -- after this child had already been
23 released from the hospital.
24 But, Your Honor, this -- the -- my argument
25 today does not go to the authority of DSS to remove

1 this child from the hospital. My argument today
2 goes to a duty that they -- that this hospital owed
3 to [redacted] to form -- to perform adequate and -- and
4 proper psychosocial assessments and to obtain the
5 information that was necessary to go into the
6 overall plan, and they were to participate in this
7 discharge plan. There's no indication that the
8 social worker from the hospital ever even
9 participated, really, in the discharge plan. All
10 she did was report that, "We can't decide whether
11 this was non-accidental trauma or not."
12 THE COURT: Well, isn't that a decision?
13 MS. CASEY: That's not a decision --
14 THE COURT: Why isn't --
15 MS. CASEY: -- Your Honor.
16 THE COURT: -- it?
17 MS. CASEY: It's not a decision. It's -- it's a
18 reporting.
19 THE COURT: If I --
20 MS. CASEY: But it says --
21 THE COURT: If I render a decision denying summary
22 judgment and say, "Well, I think there's an issue
23 of fact. I -- I don't know -- I don't know what
24 the facts are. I think there may be an issue of
25 fact," isn't that a decision?

1 MS. CASEY: Well, that's the -- is a decision, but this
2 is a -- this is -- it is a -- on a different level
3 in terms of this social worker had the -- the
4 training and the skills to have input. And there
5 was no input into the DSS's decision with respect
6 to: "We have done an investigation, which we're
7 obligated to do under our policies, that says,
8 'What, really, are the circumstances of this child?
9 What are the socioeconomics? What are the risk
10 factors?'" That was never done and reported to
11 DSS, and that is an independent responsibility
12 apart from DSS. If DSS never --
13 THE COURT: But in the end, though, Ms. Casey, let's
14 assume they did all of that and DSS said, "Oh, no.
15 No. We think -- you know, thank you for your help.
16 It's a closed question, but release the child to
17 the parents."
18 MS. CASEY: Well, that's presuming that DSS is going to
19 do that.
20 THE COURT: DSS did do that.
21 MS. CASEY: Well, that is -- again, that's presuming
22 that DSS did that. But, again, that's an issue for
23 DSS, whether they did that or not.
24 THE COURT: No, ma'am. How can I -- I -- in -- in
25 the -- the -- to -- I can't get over this -- this

1 hump in my mind that says that -- that -- that --
2 that nobody has a right to retain custody of
3 somebody else's child, absent a court order, and,
4 upon direction, to release the child by the South
5 Carolina Department of Social Services.
6 MS. CASEY: Well, again, Your Honor, it doesn't go --
7 this argument doesn't go to that, and I understand
8 where you're -- you're --
9 THE COURT: I know your argument doesn't go to that, but
10 doesn't that cancel the argument?
11 MS. CASEY: No, Your Honor, it doesn't. Because
12 presuming that Mrs. Nemark or -- or the other
13 social workers that were involved had done the
14 appropriate assessment, I think that it is fair and
15 it's a question of fact for the jury to determine
16 that if that had been done, a reasonable social
17 worker would have never made the decision to remove
18 that child. So it would have been taken out of --
19 it would not have been in the hospital's hands to
20 begin with.
21 THE COURT: But DSS made its own call about that.
22 MS. CASEY: They made their call based on interactions
23 with the hospital. It was not an independent call
24 just saying, "We're making this" -- their -- their
25 investigation had just started the day -- just

1 shortly before this child was released from the
2 hospital.
3 The social workers over that four-day period
4 of time were in the best position to observe the
5 family, to interview the family, to interview
6 family -- other family members, and to find out the
7 status of the socioeconomics, what the risk factors
8 were, and that was never done. It clearly was done
9 by DSS and the hospital after the child was
10 catastrophically injured, but those systems were in
11 place during this first hospitalization. They were
12 not utilized. They were not undertaken, and as a
13 result of that, inadequate information was given to
14 a department that made a decision to remove this
15 child from the hospital and give him back --
16 THE COURT: What was inadequate?
17 MS. CASEY: Inadequate --
18 THE COURT: What was inadequate?
19 MS. CASEY: The inadequate information.
20 THE COURT: Yes, ma'am.
21 MS. CASEY: The inadequate information was that the -- a
22 nurse had reported that she had spoken with the
23 grandmother in a private manner and that the
24 grandmother had been concerned about the -- there
25 being some bruises on the child earlier. The

1 inadequate information with respect to -- there was
2 no information gained with respect to the job
3 status of the -- the mother, the father. There was
4 no information gained with respect to any
5 concerns --
6 THE COURT: What did that have to do with child -- with
7 the claim with child abuse?
8 MS. CASEY: All of that goes into risk factors that are
9 to be considered and taken in -- or taken into
10 consideration when one is doing an evaluation,
11 especially in light of --
12 THE COURT: Whether or not mother and father have a job?
13 MS. CASEY: Yes, sir. They do because that creates
14 stresses in the family --
15 THE COURT: I see a lot of those most every day.
16 MS. CASEY: Well, it creates stresses in the family, and
17 it may not -- it does not necessarily predispose
18 anyone to -- to abuse their child, and I am not
19 saying that, whatsoever. But what I am saying is
20 that is a risk factor that goes into an assessment
21 and is to be taken into consideration in light of
22 all the other facts that are in the case.
23 And in this particular case, we had an
24 unexplained injury. The parents did not have a
25 reasonable explanation for how the injury happened.

1 We have children -- basically, children having
2 children. These were very young parents, 18 and
3 19. They were not high school graduates. They
4 were living, I think, within the poverty level or
5 the definition of the poverty level. The hospital
6 was even concerned that they had poor parenting
7 skills. And then you have a child who has an
8 injury that's unexplained and is potentially an
9 injury that was caused by abuse from somewhere.
10 And there was no investigation from the hospital to
11 determine if these parents were really at -- at
12 risk for injuring this child either --
13 THE COURT: But look. Isn't the bottom line that the
14 hospital had to render an opinion looking at the
15 injury to the child and be able to say to -- to a
16 reasonable degree of medical certainty -- that
17 would be the standard if you sued them for
18 malpractice on the medical end -- that this injury
19 was most probably caused by child abuse?
20 MS. CASEY: I think that -- that -- that --
21 THE COURT: And they could not say that.
22 MS. CASEY: They could not say that. You're right.
23 THE COURT: Well, then, what are they to do? If they
24 can't say -- if they can't relate the injury to the
25 risk factors that -- poverty, young, single,

1 unemployed -- if they can't relate the injury to
2 the risk factors, how can they possibly hold the
3 child?
4 MS. CASEY: And, Your Honor, I'm not talking about
5 holding the child. I'm talking about getting
6 adequate information and reporting to the DSS so
7 they can make a reasonable --
8 THE COURT: Well, the -- the -- the lynchpin information
9 is: We can't say that this injury was the result
10 of child abuse, based on our -- our thorough -- and
11 they did a thorough -- they kept the child three
12 days -- based on a thorough -- or might've been
13 four -- thorough medical examination. We can't say
14 that this injury -- the focus is on whether the
15 child was abused, not whether the parents had risk
16 factors. We can't say this injury was caused by
17 child abuse.
18 MS. CASEY: From a medical perspective.
19 THE COURT: Well, that's the bottom line.
20 MS. CASEY: Well, Your Honor, it's not --
21 THE COURT: Somebody -- you can have all the risk
22 factors you want, but as long as nobody can say
23 that the injury is caused by child abuse, there's
24 nothing to be done.
25 MS. CASEY: I disagree with -- with Your Honor in that.

1 I think that the -- the -- the argument is that we
2 as the hospital cannot say from a medical
3 standpoint -- from a -- just pure medical
4 standpoint that this child suffered child abuse.
5 However, we have a high index of suspicion. We
6 can't prove it, but we have a high index of
7 suspicion. The -- and on top of, we have a litany
8 of risk factors that may contribute to that, and we
9 believe that based on those -- those findings and
10 factors, which were never discussed or disclosed to
11 anyone in the DSS before they made their decision
12 to discharge the patient, then there should be more
13 that will go into this discharge planning with
14 respect to that -- that the social worker is
15 involved in, instead of just releasing the parents
16 -- the releasing of the child to the parents and
17 say, "Go and take some parenting classes." There
18 could've been some supervision implemented. There
19 are a number of things, and -- and --
20 THE COURT: What -- what right --
21 MS. CASEY: -- our experts are going to talk about that.
22 THE COURT: What right does DSS -- obviously, the -- the
23 hospital cannot implement, carry out a -- a post-
24 discharge plan with respect to the custody of the
25 child. That's -- that's the -- that's the

1 providence of DSS.
2 MS. CASEY: No, sir. But they can carry out --
3 THE COURT: Listen to me.
4 MS. CASEY: Yes, sir.
5 THE COURT: What -- what -- what right would DSS have to
6 impose a plan on a child -- on a -- on the parents
7 of a child just because risk factors existed if --
8 if no one was able to say this injury is a result
9 of child abuse?
10 MS. CASEY: Well, Your Honor, they did.
11 THE COURT: No. Answer -- answer my question.
12 MS. CASEY: Okay. What right?
13 THE COURT: What -- does DSS have the statuary right to
14 -- to -- to intervene in the parent-child
15 relationship simply because these parents had every
16 risk factor you say was -- was relevant to a
17 consideration of this case --
18 MS. CASEY: I --
19 THE COURT: -- if the injury could not be attributed to
20 child abuse?
21 MS. CASEY: Well, Your Honor, I believe that the -- the
22 statute does, based on the -- the -- that the right
23 that DSS has to -- and -- and the right that they
24 have to -- if they feel, based on just the
25 preliminary findings, they can take the child if

1 they want to, so yes they do have --
2 THE COURT: They have to have a reasonable basis to do
3 that.
4 MS. CASEY: Well, they -- and I think those risk factors
5 and the injury would have been a reasonable basis
6 had they determined that it was so. I believe that
7 that could have been implemented. So, yes, they
8 do --
9 THE COURT: I'm not a family court judge, but that
10 sounds farfetched to me.
11 MS. CASEY: They do have the right to intervene. And --
12 and there are a number ways -- and I am not a
13 family law attorney, but my understanding of the
14 statute is that they can intervene and those
15 interventions are various tools that -- as a matter
16 of fact, there was -- part of the plan was that the
17 parents were to get some parenting classes, so,
18 yes, the DSS had the authority to tell these
19 parents, "You need to do more than just take this
20 child home and come back and have the reassessment
21 in a week at the hospital." And with respect to
22 the hospital, I do believe that they have the right
23 to do post-discharge planning, not with respect to
24 custody of the child.
25 THE COURT: They can't impose it.

1 MS. CASEY: Not with respect to custody of the child,
2 but with respect to treatments that -- and --
3 THE COURT: Of course.
4 MS. CASEY: --and interventions. They can recommend
5 services. They can implement and help the parents
6 implement plans that train them, help them cope.
7 They can arrange psychological care if -- if -- if
8 that was -- is necessary. But we never got beyond
9 to see if that was necessary because the
10 appropriate assessments weren't done. So it goes
11 beyond whether DSS is going to take control of the
12 child or whether they have the authority. It --
13 there's -- there's so -- it's -- it is a matter of
14 there was not an appropriate assessment done and
15 this hospital and its employees, being the social
16 workers, otherwise, owed a duty to this child,
17 which they have that special relationship with, by
18 virtue of the fact that he was there voluntarily,
19 he was under the custody and control of the
20 hospital at that time -- they had the -- the access
21 to him and to the family members at any time they
22 needed it. They could have done the appropriate
23 assessments, and I think that's the duty, and I
24 believe that's the reason that duty exists, and I
25 think that duty exists by law.

1 And as a -- and -- and we have the sufficient
2 evidence and the facts to say that duty was
3 violated, and that is a question for the fact
4 finder of the jury to determine if it was violated.
5 We know there was a duty there. We believe it.
6 This is our job to --
7 THE COURT: No. We don't know there was duty. You --
8 you're telling me that -- that your position is
9 that there was a duty.
10 MS. CASEY: Yes, Your Honor. But you said in the last
11 hearing that -- you said, "I'll give you that there
12 was duty to this child while he was in the custody
13 and control in the hospital."
14 THE COURT: That is to -- to maintain -- to keep him
15 safe in the hospital. To keep him safe from injury
16 in the hospital.
17 MS. CASEY: And I believe the duty goes beyond just
18 keeping him safe in the hospital.
19 THE COURT: It was not a duty -- I did not mean -- mean
20 to imply or certainly didn't express that there was
21 a duty of the hospital to -- to -- to perform -- to
22 take action in spite of DSS's direction.
23 MS. CASEY: Well, Your Honor, if -- if -- if -- and I'm
24 sorry if I misunderstood that.
25 THE COURT: And -- and what I'm saying is: If they'd

1 done everything that they could have done in -- in
2 -- in -- in identifying risk factors and all that,
3 if DSS says release the child to the parents, they
4 have no right, let alone a duty, to hold the child.
5 And in any event, the statute that gives them a
6 super -- sort of a super right to hold the child
7 after they make a determination only gives them, I
8 think, what 20 -- 24 hours? 48 hours?
9 MR. TODD: It's 24 in South Carolina; 12 in North
10 Carolina.
11 THE COURT: 24 in South Carolina and 48 in North
12 Carolina.
13 MS. CASEY: Right.
14 THE COURT: And they exceeded that in any event.
15 MS. CASEY: Your Honor, it doesn't go to holding the
16 child. That's not the issue. The issue is the
17 appropriate -- the duty to do an appropriate
18 assessment. That was not undertaken, and as a
19 result of that, the information that was necessary
20 that -- and is supported by our expert affidavits
21 and -- and will be supported by their testimony was
22 not relayed to the appropriate person in order that
23 decisions would be made. And I believe the fact --
24 finder of fact will -- can determine and -- and a
25 reasonable juror could find that as a result of

1 that, this child was given back to the parents and
2 he was injured and it was foreseeable that that
3 would happen. And that is the reason that summary
4 judgment is not appropriate in this circumstance
5 and this case because there is a duty. I believe
6 our experts, under the -- the rules, show -- will
7 show that there was a breach of that duty, and they
8 will show what the standard of care is. And --
9 THE COURT: Now, tell me whether that duty -- whether
10 the breach of the duty -- if we assume that to be
11 true -- was the approximate cause of the -- of the
12 ultimate catastrophic injury of the child in this
13 tragic case.
14 MS. CASEY: Well, Your Honor, the approximate cause
15 issue is, yes. Yes, it was. It -- because it's
16 not only, but for, I believe, the cause -- the
17 cause, in fact, but -- but for the negligence of
18 these hospital employees and their failures to
19 perform adequate assessments that -- that
20 information was not obtained that would have
21 enabled all concerned to make a reasonable decision
22 with regard to the future safety and protection of
23 this child. And failure to do so based on the
24 injury that he presented with, it was foreseeable
25 and, but for that -- that inaction, probable that

1 this child was going to suffer additional injury,
2 and that's exactly what happened.
3 THE COURT: I disagree with you.
4 Let me hear from the other side.
5 MR. TODD: Your Honor, the -- the order for summary
6 judgment is appropriate. The -- the plaintiff in
7 the motion for reconsideration really does not make
8 any new arguments.
9 The -- the -- the crux of the plaintiff's case
10 is that some -- for some reason, Charlotte
11 Mecklenburg Hospital should have retained custody
12 of this child for some indeterminate period of
13 time, even in the -- in light of DSS advising them
14 or instructing them to discharge the child to his
15 parents. The Charlotte Mecklenburg Hospital had no
16 right, had no duty to maintain the child or to
17 retain custody of the child. There's a statutory
18 scheme that sets forth the duties and obligations
19 surrounding removal of a child from a parent. It
20 rests squarely with DSS and the courts.
21 THE COURT: I -- let me -- I -- I do want to ask you
22 this: Is -- do you have -- have any opinion about
23 whether if -- if DSS -- if the hospital had -- had
24 -- had attributed to these parents every risk
25 factor there was -- shall we call it

1 "stereotyping?" Isn't that the proper term now? --
2 attributed to these parents every risk factor
3 possible, but, yet, could not -- but, yet, could
4 not say that the injury was a result of abuse, what
5 -- what was DSS's right, without -- without --
6 without some finding that there was -- that the --
7 that -- that the injury was most probably abuse by
8 -- by -- by the -- you know, the -- the medical
9 standard of abuse? And assuming that they
10 identified all the risk factors, what right did --
11 did DSS have to take the child away, if any?
12 MR. TODD: Well, Your Honor --
13 THE COURT: Do you know?
14 MR. TODD: -- I -- I -- I don't know. I don't know. I
15 would defer to Mr. Frawley, who represents DSS on
16 that, but --
17 THE COURT: Oh. Well, I -- all right. I want to
18 hear from him.
19 MR TODD: Well, I don't mean to put the burden on
20 him, but you can't -- I don't think that there's
21 any court that would say because of risk factors or
22 -- or, you know, low socioeconomics, whether you
23 have a job or not, that they're going to take a
24 child away from his parents without something else.
25 In -- in this case, you know, what the plaintiffs

1 are arguing is that -- is that -- that if you -- if
2 you read their -- their motion on the -- for
3 reconsideration, is that some -- for some --
4 somehow, through someway Charlotte Mecklenburg
5 Hospital should have done a home visit. And I'm
6 not sure of the mechanism for the hospital in -- in
7 Charlotte doing a home visit in York.
8 THE COURT: I don't know what right they have to do it.
9 MR. TODD: I don't know how they would do that.
10 THE COURT: Absent the consent of the parents.
11 MR. TODD: But -- but DSS did a home visit, and --
12 and there was a -- yeah. The DSS was continuing
13 its -- its investigation of this matter. They did
14 a home visit; they notified the sheriff. And, you
15 know, the -- the -- they were continuing to
16 investigate. The parents entered into a consent
17 order where they agreed to do certain things such
18 as parenting classes. But -- but the hospital had
19 no duty -- they had no right --
20 THE COURT: The -- the -- the parents -- and I --
21 I don't remember that. The parents did, as a
22 result of DSS's own investigation, enter an order
23 to -- to, among other things, go to parenting
24 classes -- attend --
25 MR. TODD: Where --

1 THE COURT: -- parenting classes?
2 MR. TODD: They did enter into -- when DSS -- on those
3 -- a -- (To Mr. Frawley) What is the term for
4 that?
5 MR. FRAWLEY: (To Mr. Todd) Safety plan.
6 MR. TODD: A safety plan.
7 THE COURT: A safety plan?
8 MR. TODD: That --
9 THE COURT: Okay.
10 MR. TODD: That they agreed that DSS could come in and
11 do a home visit, and they agreed to do parenting
12 classes. Now, the parenting classes hadn't
13 actually occurred at the time the child came back
14 to the hospital.
15 THE COURT: Right.
16 MR. TODD: But the parents did enter into a safety
17 plan with DSS that included DSS having the right to
18 come in and do a home visit. But -- but the --
19 really the -- the crux -- as you -- as you
20 identified, the crux of the case is -- is that the
21 hospital had no duty to maintain this child when
22 DSS has advised them to discharge the child to the
23 parents.
24 THE COURT: Now, of course, what she's saying is
25 that they would have if the hospital had done this

1 -- submitted -- given more information. What --
2 what -- what all -- what was in the report that the
3 social worker made?
4 MR. TODD: Well, the social worker, in her
5 testimony, she says, "I'm essentially a liaison
6 between the medical doctors and the DSS social
7 workers."
8 THE COURT: Uh-huh.
9 MR. TODD: And she reported the -- the findings that
10 the doctors -- you know, the medical findings to
11 DSS so DSS could make its decision.
12 THE COURT: So is it -- is it your -- is it
13 your position, then, that this social worker did
14 not occupy a position that is consistent with what
15 -- what the plaintiff's experts say her position
16 was?
17 MR. TODD: Well, I'm -- I --
18 THE COURT: You see what I'm saying?
19 MR. TODD: Well, she interviewed the parents, and
20 she talked with the doctors, and she provided the
21 information that she obtained to DSS. But the
22 ultimate decision is for DSS to make.
23 THE COURT: Well, I -- I don't disagree with that, but
24 I -- but I -- I guess what I'm saying is: Did she
25 occupy the role that they say she occupied, or was

1 she more -- you say she says she's a liaison.
2 MR. TODD: To --
3 THE COURT: That's a whole lot different than what --
4 than -- than what they're saying is the role
5 that -- that the social worker occupies.
6 MR. TODD: What they're saying is that she's the one
7 who makes the decision, not DSS.
8 THE COURT: Well --
9 MR. TODD: And she's not the decision maker --
10 THE COURT: No. I don't think --
11 MR. TODD: -- on the --
12 THE COURT: -- think that.
13 MR. TODD: -- discharge of the child.
14 THE COURT: I -- I just think they imposed more --
15 more obligation upon her than your description of
16 her -- of her job description is, and I'm -- I'm
17 saying, do you -- did -- I'm asking you: Did --
18 did -- did -- did the social worker occupy a
19 position with a job description consistent with
20 what they say it ought to have been?
21 MR. TODD: No, sir.
22 THE COURT: Okay. All right. Thank you.
23 Mr. Frawley, give me your full name, please,
24 sir?
25 MR. FRAWLEY: My name is Patrick Frawley, F-r-a-w-l-e-y.

1 THE COURT: Thank you very much. I can't remember
2 if you -- I don't think you were here the last
3 time, were you?
4 MR. FRAWLEY: I was. I was.
5 THE COURT: You were?
6 MR. FRAWLEY: Yes, sir.
7 THE COURT: I'm sorry. Well, I -- that's my fault.
8 MR. FRAWLEY: I was smiling and nodding my head as Mr.
9 -- Mr. --
10 THE COURT: You didn't get a chance to talk?
11 MR. FRAWLEY: No, sir.
12 THE COURT: All right. Mr. Frawley, tell -- tell me
13 about the -- the DSS paradigm, all right?
14 MR. FRAWLEY: Okay. Your Honor, when -- when we
15 get called into a -- to a -- to a case -- when
16 there's an intake, we have -- depending on the
17 severity of the case, we have a certain time frame
18 within which to -- to -- to respond. And in this
19 case, we did respond quickly. And I -- I don't --
20 I wasn't prepared to argue today, so my -- my
21 recollection is the call-in was December 6th. And
22 we responded; we had an on-call caseworker who did
23 respond, went to Charlotte, did see the parents,
24 did talk to hospital personnel, did -- was able to
25 make her initial assessment. And then the next day

1 -- because she was an on-call caseworker -- they
2 staffed the case, and the case was transferred to
3 CPS or Child Protective Services case workers, who
4 -- who typically handle those cases. She was on-
5 call that night. She responded, got the initial
6 information, and then it was transferred the next
7 day.
8 THE COURT: All right.
9 MR. FRAWLEY: Now, I think the child was released the
10 8th or the 9th. I don't remember. Within three
11 days/four days possibly.
12 THE COURT: Three or four days.
13 MR. FRAWLEY: During that period of time, we had a --
14 a case worker, Ms. Devandra Hill, who was -- who
15 was doing some work on it. We also had a
16 supervisor, whose name escapes me now, but -- but
17 she was our supervisor who worked with Ms. Hill and
18 was in that -- that initial staffing. That
19 supervisor had direct contact with the hospital
20 social worker, repeatedly trying to find out was it
21 -- and you -- Your Honor's probably seen the term
22 "NAT," non-accidental trauma -- was it something
23 that looks like abuse, or was it possibly
24 accidental trauma?
25 And the -- the social worker she was dealing

1 with, pretty much by the telephone, was a social
2 worker with whom she'd dealt several times before
3 with --
4 THE COURT: Is all this --
5 MR. FRAWLEY: -- this hospital.
6 THE COURT: -- in discovery, by the way --
7 MR. FRAWLEY: That --
8 THE COURT: -- already?
9 MR. FRAWLEY: Yes.
10 THE COURT: Okay.
11 MR. FRAWLEY: Yes. That -- and that's in -- that's in
12 the DSS dictation that was provided.
13 THE COURT: All right. All right. I haven't read all
14 of it.
15 MR. FRAWLEY: Yes, sir. Well, there -- it --
16 THE COURT: It's about 8 inches thick.
17 MR. FRAWLEY: It's a bunch to read. But -- but she
18 -- she did have several conversations and telephone
19 conversations with the social worker for purpose of
20 finding out: Did the doctor feel this was NAT?
21 Because that -- that was going to be one of the
22 pivotal issues: Was the etiology of the injury
23 possible abuse? And -- and we were never able to
24 get a -- a clear -- clear read on that.
25 Now, we also got information from the social

1 worker in --
2 THE COURT: What you got --
3 MR. FRAWLEY: -- those calls --
4 THE COURT: -- was a -- was an opinion that said,
5 "We can't say," right?
6 MR. FRAWLEY: That -- yes, sir. Yes, sir. What --
7 what they were saying in -- in -- in the -- the --
8 the phone call discussions in there or the --
9 the -- the DSS dictation of those phone calls from
10 our supervisor, based on the phone calls with the
11 social worker, was that she was going to talk to
12 the doctor -- with the doctor who, I think, has
13 been deposed in this case. She was going to talk,
14 and -- and that doctor was going to let us know,
15 and -- and we never got a clear read --
16 THE COURT: You say "she"? The social --
17 MR. FRAWLEY: The --
18 THE COURT: -- worker --
19 MR. FRAWLEY: The --
20 THE COURT: -- was going to talk --
21 MR. FRAWLEY: Well, the social worker was going to
22 talk to the doctor and then be able to relay that
23 information back to us. And there was also a phone
24 call, as I recall, with the doctor herself, and the
25 doctor could never say clearly whether it was non-

1 accidental trauma or accidental trauma. In other
2 words, we never had a clear read that it was
3 accidental. Now, as far as the --
4 THE COURT: Is there -- is there a threshold burden of
5 -- of proof, if you -- if I --
6 MR. FRAWLEY: Well --
7 THE COURT: -- can use that term --
8 MR. FRAWLEY: Well, the -- the --
9 THE COURT: -- that -- that DSS operates under for
10 that purpose?
11 MR. FRAWLEY: Yes, sir. The burden we have to look
12 at -- if we go in there and our -- our caseworker
13 and our supervisor -- because it's not one person's
14 decision; they staff it. The -- the burden is that
15 if -- if we believe that there is a -- a threat of
16 possible abuse there, we'll staff it and then they
17 can, you know -- people use the term --
18 THE COURT: So --
19 MR. FRAWLEY: -- we, you know --
20 THE COURT: -- based on the information --
21 MR. FRAWLEY: -- we "take the child."
22 THE COURT: -- they had, they believed there was a
23 threat of possible abuse?
24 MR. FRAWLEY: Well, based on the information they had,
25 they didn't know. We -- we knew we had these risk

1 factors.
2 THE COURT: Yes sir.
3 MR. FRAWLEY: But, Your -- Your Honor, the term you used
4 was -- I forget the term you used, but "profiling."
5 We -- we can't --
6 THE COURT: "Profiling" is what I should've used.
7 MR. FRAWLEY: Yes, sir.
8 THE COURT: Yes.
9 MR. FRAWLEY: If -- if -- if we removed every child
10 whose parents were young and poor and -- and -- and
11 these were --
12 THE COURT: Single.
13 MR. FRAWLEY: -- these were Caucasians or single,
14 without jobs, you know, with -- with stresses,
15 there'd be a lot more children removed. There --
16 there's a threshold showing we have to have.
17 Now, if we -- if we feel that and we want to
18 remove that child, the burden for us is that it --
19 it's almost a preponderance of the evidence. There
20 has to be more likely than not that there was
21 abuse.
22 THE COURT: All right.
23 MR. FRAWLEY: And -- and before we get to that point,
24 there has to be some indication that there was
25 abuse, and then we'll look at the risk factors.

1 Now, I -- I disagree with Ms. Casey that --
2 THE COURT: So would that -- would that, thus, then
3 require a medical finding that there was abuse in
4 -- in a -- in a -- in a -- in a -- in a case where
5 the only evidence was medical findings?
6 MR. FRAWLEY: Yes, sir. Yes, sir.
7 THE COURT: Okay.
8 MR. FRAWLEY: At least something definitive from them
9 saying it -- it -- it looks like abuse. Now, the
10 -- the --
11 THE COURT: Okay.
12 MR. FRAWLEY: -- the subdural hematomas can -- can occur
13 accidently. Not -- not just -- not just --
14 THE COURT: Right.
15 MR. FRAWLEY: -- by -- by non-accidental trauma. And --
16 and -- and that was the pivotal issue our people
17 were looking for. Do we have somebody medically
18 who can tell us, because we're not doctors, to --
19 to a medical degree of -- of certainty, that it's
20 more probable than not that -- that this was non-
21 accidental trauma? We never got that. But as far
22 as the risk factors, that information was conveyed
23 to us, as well. Now, we have a -- I mean, we --
24 THE COURT: By the hospital?
25 MR. FRAWLEY: -- can recognize -- by the hospital, by

1 -- by the social worker, and by when our caseworker
2 went there, she was able to pick that up when --
3 when she -- she got there. But -- but we also had
4 other information about these being young parents
5 and possibly needing supervision. In fact, when we
6 first got to the hospital, we were under the
7 impression that -- that -- that they thought we
8 were the sitters, that we were there to relieve the
9 sitters. So it -- it -- it wasn't an issue that
10 had risen to that level, yet, but if we feel we're
11 going to remove it and -- and they don't agree to a
12 safety plan -- you heard the term "safety plan"?
13 THE COURT: Yes sir.
14 MR. FRAWLEY: -- we go to them and we say, "Here's what
15 we would like to do." If -- if we're going to
16 remove the children, you know, we're going to put
17 them -- we have to look for relative placement
18 first, have a family meeting. There's a panoply of
19 things we have to do, but we go to the parents and
20 say, "Here's the plan we'd like to propose to you.
21 Do you voluntarily agree with this?" If they do
22 and they sign it, then we -- we activate that plan.
23 If they say, "No. We're not going to do that. I
24 don't want you taking my children out," then we
25 have an obligation to go to family court and -- and

1 then we have to present our case and we have to --
2 to convince a family court judge that it's more
3 likely than not that this occurred, for --
4 THE COURT: So, was the --
5 MR. FRAWLEY: -- the judge to -- to rubberstamp our --
6 our removal.
7 THE COURT: So, was the presentation of the safety plan
8 a precursor to taking the child if they did not
9 agree to it?
10 MR. FRAWLEY: If -- no, sir. If we wanted to remove the
11 child, we could've stuck that in there, which we
12 did not do.
13 THE COURT: Right.
14 MR. FRAWLEY: But -- but if we wanted to remove the
15 child and we said, "Remove the child. Place him
16 with your grandmother or with your mother, Ms.
17 Williams" --
18 THE COURT: Right.
19 MR. FRAWLEY: -- and they said, "No. We don't want to
20 do that," then, if we felt we needed, we -- we
21 could either say, "Well, fine. We're going to
22 leave it where it is," if we didn't feel we had the
23 evidence. If we felt we did have the evidence, we
24 would've had law enforcement come in. DSS can't
25 remove them; it's got to be law enforcement,

1 with -- with our -- with our direction. And then
2 we would've had to go to a family court judge and
3 convince a family court judge that -- that it's
4 more likely than not that there was abuse at that
5 point. And there'd be kind of a -- a short
6 hearing --
7 THE COURT: So -- so, the safety plan is not -- the
8 safety plan is just what it is? That's -- that's
9 as far as you go presenting a safety plan that does
10 not include removal?
11 MR. FRAWLEY: It can include removal.
12 THE COURT: Well, I know it can, but what I'm saying is:
13 In this instance, is it DSS's position that the
14 safety plan went as far as the -- as the evidence
15 permitted them to go at that point?
16 MR. FRAWLEY: Yes, sir.
17 THE COURT: All right. Which it did not include
18 removal?
19 MR. FRAWLEY: We did not include removal. And with
20 regard to the investigation, statutorily we have 45
21 days --
22 THE COURT: Yes, sir.
23 MR. FRAWLEY: -- from the intake to complete our
24 investigation. If we need additional time, we can
25 ask for another 15 days, during which time there

1 are staffings and certain things we have to do,
2 which we'll discuss on another day. But -- but
3 that -- that was done, and then the second injury
4 occurred within that initial 45 days.
5 THE COURT: Okay. But the safety -- the safety plan
6 predated the second injury, didn't it or did it
7 not?
8 MR. FRAWLEY: Yes. Oh, there are several safety plans.
9 So, I mean --
10 THE COURT: But, I mean --
11 MR. FRAWLEY: -- they -- they kept updating the safety
12 plans.
13 THE COURT: Okay. So -- oh. All right.
14 MR. FRAWLEY: We had a safety plan that first night.
15 There was a safety plan entered that first night
16 which basically said, "You will not remove the
17 child from the hospital. You will do what the
18 hospital tells you to do with regard to treatment
19 of the child. You will comply with whatever" --
20 THE COURT: All right.
21 MR. FRAWLEY: -- "they say."
22 THE COURT: All right.
23 MR. FRAWLEY: But we --
24 THE COURT: And then there was --
25 MR. FRAWLEY: -- we did not have anything in there about

1 removing the child.
2 THE COURT: But then -- then -- then after removal --
3 after discharge but before the -- the second
4 injury, there was a safety plan in place that
5 did -- dealt with after discharge?
6 MR. FRAWLEY: Yes. In -- in fact, it was updated
7 several --
8 THE COURT: All right.
9 MR. FRAWLEY: -- several times.
10 THE COURT: All right.
11 MR. FRAWLEY: But never -- never including removal.
12 THE COURT: All right.
13 MR. FRAWLEY: And as far as parenting classes, that's
14 typically considered treatment. We have assessment
15 up until the point that we determine it's indicated
16 or they agree with it, and then from that point,
17 then it transfers to the treatment plan, which --
18 which would be -- could be parenting classes, could
19 be any number of things. We were still in the
20 assessment period.
21 THE COURT: All right. Let me think.
22 Now, let me ask you the hardest question --
23 MR. FRAWLEY: Yes, sir.
24 THE COURT: -- I guess. Assuming the -- the -- the --
25 the numerous risks factors, you know, youth,

1 single, unemployed, whatever else there may be --
2 assuming you identify those but can't connect those
3 with an injury that is -- say if the injury is --
4 is probable abuse, do you nevertheless have the
5 right to take any action --
6 MR. FRAWLEY: We have the right --
7 THE COURT: -- absent a connection between the injury --
8 or absent a determination that the injury was
9 probable abuse?
10 MR. FRAWLEY: We have the right to take the action, but
11 we have to pass muster, either get a safety plan
12 where the parents say, "Sounds good to us. Go
13 ahead and do it," or we have to pass muster with a
14 -- with a family court judge and prove to him that
15 based on what we've got, the -- the risk factors
16 and somebody with -- with -- with more medical
17 weight than we've got saying it's -- it's an injury
18 that is caused by non-accidental
19 trauma.
20 THE COURT: That's what I'm saying.
21 MR. FRAWLEY: Yes, sir.
22 THE COURT: You -- is -- is -- is everything after that
23 positive necessarily on a finding that -- that
24 there was non-accidental trauma?
25 MR. FRAWLEY: Yes, sir. That's why that --

1 THE COURT: All right.
2 MR. FRAWLEY: -- was a pivotal issue for us.
3 THE COURT: All right.
4 MR. FRAWLEY: But we were aware of the risk factors and
5 that information was discussed with us by the
6 hospital.
7 THE COURT: Thank you.
8 Ms. Casey anything else, briefly?
9 MS. CASEY: Well, yes, Your Honor. Briefly. The -- the
10 hospital did tell the DSS that they felt that they
11 could not find what the cause of the -- of the --
12 the hemorrhages were, but I think the literatures
13 replete that children that are three years old
14 rarely have an accidental injury such as this. So
15 that's one of the reasons that the -- the index of
16 suspicion was so high. There were identified
17 potentially poor parenting skills and some
18 supervisory issues, but this was never gone into in
19 depth to have an interview in the hospital by the
20 social worker with respect to that some of these
21 risk factors -- and it's not just the risk factors,
22 and it's not profiling.
23 THE COURT: I -- I thought Mr. Frawley said that -- that
24 -- that as a result of what the hospital did, that
25 the DSS person actually directly interviewed the

1 parents?
2 MS. CASEY: Well, that interview was just the one time
3 in the hospital, and --
4 THE COURT: Well, no. But they did it.
5 MS. CASEY: -- it was very briefly. It was very
6 briefly, and there was no information to gain --
7 THE COURT: What is "very briefly"?
8 MS. CASEY: She was there probably for about 45 minutes.
9 THE COURT: Oh.
10 MS. CASEY: So, that was not a long -- and, then, she
11 was in the process of talking to other individuals,
12 too. So this was not a -- an in depth interview
13 that a social worker would have been -- and would
14 have been trained to do. This was an on-call
15 individual who was not a trained master-degreed
16 social worker that could have gone and done an in
17 depth interview with the parents and discussed not
18 only the risk factors, but have -- could have gone
19 into further detail about the facts and
20 circumstances surrounding the discovery of this
21 child being unresponsive, what was going on, things
22 of that nature. So there was a -- a very -- there
23 was a -- just a lack of information that was
24 obtained during that period of time when the --
25 they were in the best position to do that.

1 And, there again, I get the crux of the matter
2 is not whether or not the hospital had the right to
3 maintain custody of this child. It is whether or
4 not the hospital did the -- the -- provided the
5 services that they were obligated to provide, and
6 that would be to do an assessment that is an
7 appropriate assessment, obtain crucial information,
8 pass it along to the people who needed to have that
9 information. And this is a collaborative effort.
10 This DSS and the -- the hospital don't work in two
11 vacuums. It's all a collaborative effort. And the
12 -- and the DSS individual said they rely on the
13 information that the hospital gives them. So, with
14 respect to that, it is -- I believe that we have --
15 - have created and -- and we've shown the duty. We
16 haven't created it. We've not created the duty.
17 The duty exists. But I believe that we have given
18 more than the scintilla of evidence that would
19 overcome any motion for summary judgment at this
20 point in time and allow this case to go forward and
21 then have experts or other witnesses talk about the
22 facts and circumstances, standard of care, and the
23 foreseeability issues, which, again, the proximate
24 cause is a fact and a question for the jury. And
25 it's there, and -- and summary judgment is just not

1 proper at this time.
2 THE COURT: Okay. All right. Obviously, I understand
3 I've said this before. This is a tragic case, but
4 I -- I still find that -- that -- that the -- the
5 hospital has not violated any legal duty in respect
6 to the child and clearly did not have an -- an -- a
7 right to -- the only -- the only logical conclusion
8 is that the -- at some point, based on more
9 investigation, the hospital would have said, "Don't
10 -- we're not going to release the child." I
11 suppose that your argument is that -- that -- that
12 -- that as a result -- if the hospital had done
13 more investigation, the DSS would've said, "Don't
14 release the child." But I think -- I -- I -- I
15 think the -- you know, there -- there are
16 inferences that you want me to draw that are not
17 reasonable and issues of fact that are not genuine.
18 So I'm going to deny your motion. I haven't heard
19 anything new and -- and don't find any reason to
20 change my position. And Mr. Frawley's presentation
21 to me has confirmed that. I'll do a Form 4 order.
22 That's it.
23 (Whereupon, the proceeding in the
24 above-entitled matter was adjourned
25 at 10:23 a.m.)

1 (*This transcript may contain quoted material.
2 Such material is reproduced as read or quoted
3 by the speaker.)
4 (**Certificate accompanies sealed original
5 only.)

STATE OF SOUTH CAROLINA
COUNTY OF YORK
Elizabeth Hope Rainey, et al.,
[ ] Plaintiffs,

vs.

The Charlotte-Mecklenburg Hospital Authority, et al.,
[XX] Defendants.
Check box above indicating submitting party

IN THE [xx] COURT OF COMMON PLEAS
[ ] FAMILY COURT
Civil Action No. 11-CP-46-4508

MOTION AND ORDER INFORMATION FORM AND COVER SHEET

name, SC Bar no. and address of plaintiff's attorney	name, SC Bar no. and address of defendant's attorney
S. Randall Hood, Esquire McGowan Hood & Felder, LLC 1539 Health Care Drive Rock Hill, SC 29732 e-mail: other:	Monteith P. Todd Sowell Gray Stepp & Laffitte, LLC 1310 Gadsden Street, P.O. Box 11449 Columbia, SC 29211 (803) 929-1400 e-mail: mtodd@sowellgray.com other:

[XX] MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)
[ ] FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)
[ ] PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)

SECTION I: Hearing Information

Nature of Motion: Motion for Summary Judgment
Estimated Time Needed: 20 minutes Court Reporter Needed: YES [XX] NO [ ]

SECTION II: Motion Type

[XX] Written motion attached
[ ] Form Motion:
I hereby move for relief or action by the court as set forth in the attached proposed order.

_____ _____
Signature of Attorney for [ ] Plaintiff [ ] Defendant Date Submitted

SECTION III: Motion Fee

[XX] PAID – AMOUNT: $25.00
[ ] EXEMPT: [ ] Rule to Show Cause in Child or Spousal Support
[ ] Domestic Abuse or Abuse and Neglect
(check reason) [ ] Indigent Status [ ] State Agency v. Indigent Party
[ ] Sexually Violent Predator Act [ ] Post Conviction Relief
[ ] Motion for Stay in Bankruptcy
[ ] Motion for Publication [ ] Motion for Execution (Rule 69, SCRCP)
[ ] Proposed order submitted at request of the court; or,
reduced to writing from motion made in open court per judge's instructions
Name of Court Reporter: _____
[ ] Other:

JUDGE'S SECTION

[ ] Motion Fee to be paid upon filing of the attached order.
[ ] Other:

_____
JUDGE

CODE: _____ Date: _____

CLERK'S VERIFICATION

DATE FILED

Collected by: _____
(print name)

[ ] MOTION FEE COLLECTED: _____
[ ] CONTESTED – AMOUNT DUE: _____

SCCA/233 (1/2003)

Additional Counsel:

Duane M. Shaw, Esquire
Nathan J. Sheldon, Esquire
Shaw Law Firm
1169 Ebenezer Road
Rock Hill, SC 29732

Patrick J. Frawley, Esquire
Davis, Frawley Law firm
Post Office Box 489
Lexington, SC 29071

Daniel R. Settana, Jr., Esquire
McKay Cauthen Settana & Stubley, PA
Post Office Box 7217
Columbia, SC 29202

STATE OF SOUTH CAROLINA COUNTY OF YORK	)))	IN THE COURT OF COMMON PLEAS
Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted] a minor Plaintiff, v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County, Defendants.	))))))))))))))))))	Civil Action No. 11-CP-46-4508 **NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT**

YOU WILL PLEASE TAKE NOTICE that the defendant, The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, will move before the Presiding Judge of the York County Court of Common Pleas on the tenth (10th) day after service of this motion or as soon thereafter as counsel may be heard for an Order granting this defendant summary judgment pursuant to Rule 56 of the South Carolina Rules of Civil Procedure. This motion will be based on the pleadings, depositions, the discovery responses in this case, and a memorandum of law that will be presented to the Court at or before the hearing of this motion. The basis of the motion is that the plaintiff cannot show that (1) this defendant breached any duty of care which proximately caused the plaintiff's alleged injuries, and (2) this defendant is immune from liability under S.C. Code Ann. § 63-7-390 and the common law of the State of South Carolina.

FACTUAL SUMMARY

[redacted] was admitted to The Charlotte-Mecklenburg Hospital Authority on December 5, 2009. A CT scan on December 6, 2009, revealed a subdural hematoma which raised a suspicion of a non-accident injury and The Charlotte-Mecklenburg Hospital Authority notified DSS of its suspicion that [redacted] may have been a victim of a non-accidental trauma. DSS investigated the matter. The physicians at The Charlotte-Mecklenburg Hospital Authority ordered and performed additional tests and studies on Owen which were essentially normal and which revealed Owen was medically stable and ready for discharge. DSS advised The Charlotte-Mecklenburg Hospital Authority that Owen should be discharged to his parents. Pursuant to this direction from DSS, The Charlotte-Mecklenburg Hospital Authority discharged Owen to his parents on December 8, 2009. Approximately one month later, Owen returned to The Charlotte-Mecklenburg Hospital Authority with a significant traumatic brain injury. His father later pled guilty to abusing Owen and causing his traumatic brain injury in January 2010.

BASIS FOR DEFENDANT'S MOTION

The plaintiff claims that The Charlotte-Mecklenburg Hospital Authority should not have discharged [redacted] into the custody of his parents in December 2009 and that if Owen had not been discharged into the custody of his parents on December 8, 2009, his father would not have injured him in January 2010. The decision regarding the discharge of a child into the custody of his parents or to some other person or entity is a decision that must be made by the Department of Social Services, by law enforcement, or by the courts, and is not a decision which can be made by a hospital or physician.

When [redacted] presented to The Charlotte-Mecklenburg Hospital Authority in December of 2009, a CT scan performed at the hospital revealed a subdural hematoma which

raised a suspicion that [redacted] had been a victim of non-accidental trauma. The Charlotte-Mecklenburg Hospital Authority contacted the South Carolina Department of Social Services and notified it of Owen's condition and of its suspicion that Owen had been a victim of non-accidental trauma as it is required to do by statute. See S.C. Code Ann. § 63-7-310. After notifying DSS of a suspicion that Owen had been a victim of non-accidental trauma, Owen's attending physician obtained consults by an ophthalmologist, neurosurgeon, and a neurologist, and obtained additional diagnostic studies, all of which were essentially normal. After obtaining these additional studies and consults, Owen's attending physician could not rule in or rule out that Owen had been a victim of non-accidental trauma. A social worker at The Charlotte-Mecklenburg Hospital Authority reported to DSS that Owen's physician could not rule in or rule out that Owen had been a victim of non-accidental trauma. The South Carolina Department of Social Services staffed [redacted]'s case with a supervisor, two case workers, and a DSS attorney. After conducting its own investigation and discussing the case in a group, DSS instructed The Charlotte-Mecklenburg Hospital Authority to discharge Owen to his parents.

By statute, a hospital or medical provider and other professionals are required to report any suspicions of child abuse or non-accidental trauma to the South Carolina Department of Social Services. See S.C. Code Ann. § 63-7-310 The Charlotte-Mecklenburg Hospital Authority complied with that statutory duty by notifying the South Carolina Department of Social Services of the suspicion of non-accidental trauma with [redacted]. The Charlotte-Mecklenburg Hospital Authority properly treated Owen and when he was medically stable, discharged him to his parents pursuant to instructions from the South Carolina Department of Social Services. This defendant complied with its duties and obligations by reporting this matter

to the South Carolina Department of Social Services and heeding the instructions of the Department of Social Services regarding Owen's discharge.

Because the plaintiff cannot show that this defendant breached any duty to [redacted] in December 2009 and because this defendant is immune from liability pursuant to S.C. Code Ann. § 63-7-310 and the common law of the State of South Carolina, this defendant is entitled to summary judgment and the Court should issue an order granting summary judgment to this defendant.

SOWELL GRAY STEPP & LAFFITTE, L.L.C.

By: _____

Monteith P. Todd
1310 Gadsden Street
Post Office Box 11449
Columbia, South Carolina 29211
(803) 929-1400

Attorneys for Defendant, The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center

Columbia, South Carolina

Feb 22, 2013

STATE OF SOUTH CAROLINA COUNTY OF YORK	)))	IN THE COURT OF COMMON PLEAS
Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted] a minor Plaintiff, v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, The York County Sheriff's Department, and York County, Defendants.	)	Civil Action No. 11-CP-46-4508 **MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**

The defendant, The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, has moved for summary judgment in this matter because the plaintiff cannot show that this defendant breached any duty of care owed to the plaintiff and this defendant is immune from liability under S.C. Code §63-7-390 and the Common Law of the State of South Carolina. For the reasons set forth herein, this defendant is entitled to summary judgment.

FACTUAL SUMMARY

On December 4, 2009, [redacted]'s parents took him to Piedmont Medical Center for medical attention. On December 5, 2009, the physicians at Piedmont Medical Center transferred Owen to Levine Children's Hospital at The Charlotte-Mecklenburg Hospital Authority. A CT scan performed on December 6, 2009, revealed a subdural hematoma which raised a suspicion of a non-accidental injury. Levine Children's Hospital notified South Carolina DSS of its suspicion that [redacted] may have been a victim of a non-accidental trauma.

Upon notification of the suspicion of a non-accidental trauma, DSS began its investigation regarding [redacted] While DSS was conducting its investigation, the physicians at Levine Children's Hospital ordered and performed additional tests and studies on [redacted] which were essentially normal. Neither the plaintiff's mother nor maternal his grandparents suspected that anyone had abused or would abuse [redacted]. (Deposition of Kayla Lythgoe [mother] p. 144, l. 19 to p. 146, l. 8; Deposition of Charlotte Williams [maternal grandmother] p. 49, ll. 2-22; p. 52, l. 19 to p. 53, l. 1; Deposition of Larry Williams [step maternal grandfather] p. 32, l. 16 to p. 34, l. 2) Levine Children's Hospital advised DSS that it could neither rule in nor rule out non-accidental trauma as the cause of [redacted]'s injury. (Deposition of Dr. Cheryl Courtlandt, p. 61, l. 25 to p. 65, l. 21; p. 137, ll. 16-20) Levine Children's Hospital advised DSS that [redacted] was medically stable and ready for discharge. DSS advised Levine Children's Hospital that [redacted] should be discharged to his parents, that DSS had entered into a safety plan with [redacted]'s parents, and that DSS would conduct a home investigation. (Deposition of DSS employee Krista Hinnant, p. 26, l. 6 to p. 27, l. 22; p. 31, l. 22 to p. 33, l. 15; p. 80, l. 17 to p. 81, l. 5); (Deposition of DSS employee Divondra Hill, p. 71, l. 21 to p. 74, l. 23) Pursuant to directions from DSS, Levine Children's Hospital discharged [redacted] to his parents on December 8, 2009. (Deposition of Laura Newmark [social worker at Levine Children's Hospital] p. 133, l. 21 to p. 140, l. 7)

On January 11, 2010, five weeks after discharge, [redacted] was returned to Levine Children's Hospital with a significant brain injury. His father, Michael Carduff, later pled guilty to abusing [redacted] and causing his brain injury in January 2010.

The Plaintiff Cannot Establish any Duty Owed to the Plaintiff Which this Defendant Breached.

The plaintiff claims that Levine Children's Hospital should not have discharged [redacted] into the custody of his parents on December 8, 2009, and that if [redacted] had not been discharged into the custody of his parents, his father would not have injured him on January 11, 2010. The crux of the plaintiff's claim against this defendant is that Levine Children's Hospital should have taken some action to prevent [redacted] from being discharged into the custody of his parents. A hospital, however, does not have the authority to remove a child from the custody of his parents or to refuse discharge of a child to his parents when the child is ready for discharge. The decision regarding the discharge of a child into the custody of his parents or to some other person or entity is a decision that must be made by the Department of Social Services or by law enforcement. If DSS or law enforcement seeks to remove a child from the custody of his parents, this removal must be pursuant to the parents' consent or a court order.

In order to prove negligence, a plaintiff must show: (1) defendant owes a duty of care to the plaintiff; (2) defendant breached the duty by a negligent act or omission; (3) defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) plaintiff suffered an injury or damages. Steinke v. S.C. Dep't of Labor, Licensing and Regulation, 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999). If there is no duty, then the defendant in a negligence action is entitled to a directed verdict. Doe v. Marion, 373 S.C. 390, 400, 645 S.E.2d 245, 250 (2007) (citing Steinke, 336 S.C. at 387, 520 S.E.2d at 149). In this case, the plaintiff cannot point to any duty of care owed by this defendant to the plaintiff which may have been breached. Therefore, this defendant is entitled to summary judgment.

A defendant cannot be liable to the plaintiff for negligence in the absence of a legal duty owed to the plaintiff. Steinke, 336 S.C. at 387, 520 S.E.2d at 149. A legal duty can be

created by statutes, a contractual relationship, status, property interest, or some other special circumstance. Madison ex rel Bryant v. Babcock Cntr., Inc., 371 S.C. 123, 136, 638 S.E.2d 650, 656-57 (2006) (citations omitted). The determination of the existence of a duty is one of law for the court. See Doe ex rel Doe v. Wal-mart Stores, Inc., 393 S.C. 240, 246, 711 S.E.2d 908, 911 (2011) (a "court must determine, as a matter of law, whether the law recognizes a particular duty"); Marion, 373 S.C. at 400, 645 S.E.2d at 250 (citing Steinke, 336 S.C. at 387, 520 S.E.2d at 149) (same)); Cowburn v. Leventis, 366, S.C. 20, 46, 619 S.E.2d 437, 451 (2005) (same); Charleston Dry Cleaners Laundry, Inc. v. Zurich Am. Ins. Co., 355 S.C. 614, 618, 586 S.E.2d 586, 588 (2003) (same). Under South Carolina law, there is no general duty to control the conduct of another or to warn a third person or potential victim of danger. Faile v. S.C. Dep't of Juvenile Justice, 350 S.C. 315, 334, 566 S.E.2d 536, 546 (2002).

South Carolina, like most states, has enacted a comprehensive statutory scheme designed to deal with children who are suspected of being abused or neglected. Under South Carolina law, the Department of Social Services, with the assistance of law enforcement and the family court system, are the entities charged with investigating, prosecuting, and adjudicating issues relating to removing children from their home, placing them in foster care, and determining if or when a custodial parent may retain custody of his or her child. See South Carolina Code section 63-7-10 et seq. No other person or entity in the State of South Carolina has the duty or obligation to investigate child abuse or neglect cases and no other person or entity aside from the Department of Social Services, law enforcement, and the family court system has the right to deprive a parent or custodian of his or her right to raise his or her child.

South Carolina has passed a statute requiring certain persons or entities to report suspected child abuse or neglect. Under South Carolina law, physicians, nurses, healthcare

professionals, and other designated people are required to report suspected child abuse or neglect to the county Department of Social Services or to a law enforcement agency in the county where the child resides. S.C. Code Ann. § 63-7-310. This section states, in relevant part:

> A physician, nurse, . . . or any other ... health professional . . . must report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected as defined in Section 63-7-20.
>
> . . .
>
> (D) Reports of child abuse or neglect may be made orally by telephone or otherwise to the county department of social services or to a law enforcement agency in the county where the child resides or is found.

South Carolina Code Ann. § 63-7-31. Even under the statute, however, the failure to report does not create a private right of action. Doe v. Marion, 373 S.C. 390, 645 S.E.2d 245 (2007) (upholding dismissal of an action against a physician for failure to report under S.C. Code Ann. § 63-7-31 and holding that violation of this statute does not create a private cause of action).

It is uncontested that Levine Children's Hospital complied with this statutory requirement by reporting to the York County Department of Social Services that [redacted] may have been a victim of non-accidental trauma. Under Title 63 of the Code of Laws of South Carolina, the Department of Social Services is the agency responsible for implementing the child welfare scheme for the protection of children in South Carolina once it receives a report of suspected abuse. See S.C.Code Ann. § 63–7–660 (2010) (DSS may remove a child from his or her home and has legal custody of the child thereafter if there is probable cause to believe abuse or neglect has occurred); see also South Carolina Dept. of Social Services v. Randy S., 390 S.C. 100, 700 S.E.2d 250 (Ct. App. 2010) (noting that Section 63–7–1660(A) grants DSS, and only DSS, the authority to petition the family court to remove a child from custody of a parent if DSS

"determines by a preponderance of evidence that the child is an abused or neglected child"); South Carolina Department of Social Services v. Pritchard, 329 S.C. 242, 246, 495 S.E.2d 242, 244 (Ct. App. 1997) (same); Doe v. Marion, 373 S.C. 390, 645 S.E.2d 245 (same).

Despite the fact that Levine Children's Hospital reported the possible abuse to the county DSS office, the plaintiff attempts to expand the limited reach of this statute through the submission of an expert's affidavit which alleges that Levine Children's Hospital "abrogated a duty or responsibility to [redacted]." The expert's conclusions are based on this expert's interpretation of hospital accreditation standards and internal hospital policies. These conclusions are not based upon the only statutory duty owed by the hospital—the duty to report to DSS the possibility of abuse or neglect pursuant to S.C. Code Ann. §63-7-310. It is undisputed that the defendant fulfilled this duty.

It is well-settled that an expert testimony on issues of law is inadmissible. Dawkins v. Fields, 354 S.C. 58, 66, 580 S.E.2d 433, 437 (2003) (citations omitted); Hermitage Indus. v. Schwerman Trucking Co., 814 F. Supp. 2d 484, 486 (D.S.C. 1993). Because the determination of the existence of a duty is a legal question, the plaintiff cannot create a duty through expert testimony or internal policies and procedures when the duty does not exist at law. Trotter v. State Farm Mut. Auto. Ins. Co., 297 S.C. 465, 480, 377 S.E.2d 343, 351 (1988) (opinion testimony cannot create a duty that does not exist at law); Citizens and Southern National Bank of South Carolina v. Lanford, 313 S.C. 540, 443 S.E.2d 549 (1994) (Supreme Court summarily affirmed trial court ruling that internal policies and procedures do not create a duty between the parties where one does not exist at law). See also, e.g., Nat'l Convenience Stores, Inc. v. Matherne, 987 S.W.2d 145, 149 (Tex. Ct. App. 1999) ("expert testimony is insufficient to create a duty where one does not exist at law"); Richter v. Van Amberg, 97 F.

Supp.2d 1255 (D.N.M. 2000) (even where expert testimony is necessary in legal malpractice case, expert cannot create a legal duty); Hi-Tech Eng'g, Inc. v. Buiten, 2002 WL 31928573 at *4 (Mich. Ct. App. Nov. 12, 2002) ("the testimony of an expert cannot create a factual question concerning a duty where the law has not recognized one"). Thus, the plaintiff may not create or expand the legal duties of the defendant through submission of expert testimony or some internal policy.

In addition to the fact that the plaintiff cannot create a duty at law through expert testimony, plaintiff's attempts also ignore basic rules of statutory construction. In South Carolina, courts "must presume that the legislature did not intend a futile act, but rather intended its statutes to accomplish something." Denene, Inc. v. City of Charleston, 352 S.C. 208, 212, 574 S.E.2d 196, 198 (2003) (citing TNS Mills, Inc. v. S.C. Dep't of Revenue, 331 S.C. 611, 503 S.E.2d 471 1998). If broad duties to report and prevent child abuse existed in the absence of a statute, the legislature's passing of a statute to create such a duty would be futile. It would be especially futile where the statute passed by the legislature created a duty much narrower than that already in existence, as the plaintiff asserts in the instant case. Such an interpretation ignores well-recognized rules of statutory construction and is, therefore, erroneous. Simply put, there is no duty to prevent future child abuse, only to report suspected child abuse, as is set forth by statute.

While the plaintiff claims that Levine Children's Hospital breached a duty of care to [redacted] by discharging him into the custody of his parents, this defendant had neither the right nor the duty to refuse discharge of [redacted] to his parents. Levine Children's Hospital complied with its duties in this matter by reporting its suspicion of a non-accidental trauma to the South Carolina Department of Social Services. After further investigation, Levine Children's

Hospital informed DSS it could neither rule in nor rule out non-accidental trauma with [redacted] DSS, which was conducting its own investigation, advised Levine Children's Hospital to discharge [redacted] to his parents. The decision on whether or not [redacted] should be discharged to his parents was a decision for DSS, not for Levine Children's Hospital.

Under South Carolina law, any right of a doctor or hospital to retain a child suspected of being abused is limited to 24 hours. See South Carolina Code Ann. § 63-7-750. Even then, the hospital only has the right to refuse discharging the child to his custodian until a law enforcement official can arrive to determine whether the officer should take emergency protective custody of the child. After that 24 hour time period, a doctor has no more right nor duty to retain a child than does a total stranger, which is to say they have no right at all. Even then, the only entity allowed to retain custody over a child in derogation of a parent's rights is the Department of Social Services, and only if the Department of Social Services meets the statutory requirements to do so.

This Defendant is Immune from Liability for the Plaintiff's Claims

Further, this defendant is immune from liability under South Carolina section 63-7-390. This statute provides:

> A person required or permitted to report pursuant to Section 63-7-310 or who participates in an investigation or judicial proceedings resulting from the report, acting in good faith, is immune from civil and criminal liability which might otherwise result by reason of these actions. In all such civil or criminal proceedings, good faith is rebuttably presumed. Immunity under this action extends to full disclosure by the person of facts which gave the person reason to believe that the child's physical or mental health or welfare had been or might be adversely affected by abuse or neglect. (emphasis added)

S.C. Code Ann. §63-7-390.

Under this statute, anyone who participates, or takes part in, any DSS proceeding is immune from civil liability. The only way in which a person or entity is not immune from his reporting or participation under §63-7-310 is if he acts in bad faith. The South Carolina Supreme Court has defined bad faith as follows:

> The opposite of good faith, generally implying or involving actual or constructive fraud, or a design to deceive or mislead another, or a neglect or refusal to [fulfill] some duty or some contractual obligation, not prompted by an honest mistake as to one's rights or duties, but by some interested or sinister motive.

Estate of Carr ex rel. Bolton v. Circle S Enterprises, Inc., 379 S.C. 31, 664 S.E.2d 83 (Ct. App. 2008) quoting State v. Griffin, et al., 100 S.C. 331, 84 S.E. 876 (1915). See also Hoskins v. Aetna Life Ins. Co., 452 N.E.2d 1315 (Ohio 1983) ("A lack of good faith is the equivalent of bad faith, and bad faith . . . embraces more than bad judgment or negligence. It imports a dishonest purpose, moral obliquity, conscious wrongdoing, breach of a known duty through some ulterior motive or ill will partaking of the nature of fraud.") The burden to establish bad faith is on the plaintiff, as good faith is presumed by statute.

In this case, Levine Children's Hospital reported to DSS that [redacted] might have been a victim of child abuse. Levine Children's Hospital participated and cooperated with DSS in its investigation. There is no allegation in the plaintiff's Complaint nor is there any proof that this defendant acted with any fraud or failed to fulfill some duty or obligation because it had its own interested or sinister motive. Rather, the only evidence is that this defendant reported that [redacted] may have been a victim of child abuse and then participated briefly with DSS in its investigation of the matter. Thus, not only can the plaintiff not show that this defendant breached any duty of care to the plaintiff, this defendant is immune from liability under S.C. Code Ann. §63-7-390.

This motion is supported by this memorandum, the pleadings, depositions of Dr. Cheryl Courtlandt (the attending pediatrician for [redacted] at Levine Children's Hospital), Laura Newmark (a social worker at Levine Children's Hospital), Krista Hinnant and Divondra Hall (social workers at DSS), Kayla Lythgoe (plaintiff's mother), Charlotte Williams (plaintiff's maternal grandmother), and Larry Williams (plaintiff's maternal step grandfather), and the exhibits to those depositions.

SOWELL GRAY STEPP & LAFFITTE, L.L.C.

By: Monty Todd

Monteith P. Todd
1310 Gadsden Street
Post Office Box 11449
Columbia, South Carolina 29211
(803) 929-1400

Attorneys for Defendant, The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center

Columbia, South Carolina

April 17, 2013

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted], a minor	)	Civil Action No.: 2011-CP-46-4508
Plaintiff,	)	
v.	)	**PLAINTIFF'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT CHARLOTTE-MECKLENBERG HOSPITAL AUTHORITY'S MOTION FOR SUMMARY JUDGMENT**
Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center; South Carolina Department of Social Services, and Bruce Bryant, as the Constitutional Office of the Sheriff of York County, the York County Sheriff's Department, and York County,	)	
Defendants,	)	

Plaintiff Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to [redacted], a minor, through her attorneys, respectfully submits this Memorandum of Law in Opposition to Defendant Charlotte-Mecklenburg Hospital Authority's ("CMC") Motion for Summary Judgment.

FACTS

Three-month old [redacted] was alone with his father Michael on December 4, 2009, when Owen "got real stiff," turned red, and appeared to be "straining." Michael and [redacted]'s mother Kayla Lythgoe took the infant to the emergency room at Piedmont Medical Center ("PMC"). After triage and an examination, [redacted] was transferred to Carolinas Medical Center's Levine Children's Hospital ("LCH") in Charlotte, North Carolina. [redacted] was admitted to LCH during the morning hours of December 5th and medical tests were performed to

determine the cause of his physiological symptoms. A CT scan revealed a subdural hematoma, i.e. bleeding on his brain.

LCH also activated procedures for care of a suspected child abuse victim by notifying the York County division of the South Carolina Department of Social Services ("DSS") and utilizing a "CHS Suspected Abuse and Neglect" form. LCH policy also required the hospital to consult its on-staff medical social workers. According to CMC policy, the social stability of a patient's home environment is a distinct and independent factor for CMC personnel to consider during a patient's hospitalization and especially at the time of the patient's anticipated discharge. During [redacted]'s hospitalization from December 5-8, 2009, his family was contacted by CMC social workers Katie Harrison and Laura Newmark. CMC officials were concerned about suspected abuse and posted a sitter in [redacted]'s hospital room. During that four day period, [redacted]'s grandmother told a CMC nurse that [redacted] suffered a bruise just weeks earlier while in Michael's care and Michael had no explanation for the injury. After the subdural hematoma was diagnosed, neither parent could explain how the injury happened. Ms. Harrison and Ms. Newmark took very brief notes of their conversations with Michael, Kayla, and a couple other family members.

When a neurosurgeon examined [redacted] the night before his discharge, [redacted] was **medically** cleared for discharge but only "under supervision." The following day, [redacted] was discharged to his parents. The required safety plan was not attached to [redacted]'s chart at the time of his discharge. A few weeks later, Michael was again left alone with [redacted]. As he had many times before, Michael "got frustrated with" [redacted] to the point of being "angry" with the infant. When Michael left his house to take [redacted] for a car ride, Michael "shook" [redacted] in an effort to get [redacted] to quiet down. Michael later admitted to police officers he dropped [redacted] down a set

of concrete stairs that same night while [redacted] was in his car seat. Hours later, Michael and Kayla noticed [redacted] was in distress. Instead of crying, [redacted] was "moaning" and "twitching all over."

[redacted] was again rushed to PMC and later transferred to LCH where he was diagnosed with a new subdural hematoma, retinal hemorrhaging, and persistent seizures. Doctors determined [redacted] suffered an anoxic brain injury and had a very poor prognosis. He was unable to either see or hear. [redacted] received morphine for his pain and was eventually placed in hospice care. After a period of hospice care, [redacted]'s medical outlook began to improve. He was released from hospice but has suffered serious, permanent injuries. Michael, Carduff, the father of [redacted] Carduff, plead guilty to child abuse and is currently in prison.

SUMMARY JUDGMENT STANDARD

To grant a motion for summary judgment, the court must find that "there is no genuine issue as to any material fact." Rule 56(c), SCRCP. The judge is not to weigh the evidence but rather to determine if there is a genuine issue for trial. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). For claims where the preponderance of evidence burden applies, "the non-moving party is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment." Hancock v. Mid-South Mgmt. Co., 381 S.C. 326, 330, 673 S.E.2d 801, 803 (2009).

In determining whether any triable issues of fact exist, the evidence and all reasonable inferences must be viewed in the light most favorable to the party opposing summary judgment. Summer v. Carpenter, 328 S.C. 36, 492 S.E.2d 55 (1997); Pye v. Aycock, 325 S.C. 426, 480 S.E. 2d 455 (Ct. App. 1997). Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law. Brockbank v. Best Capital Corp, 341 S.C. 372, 534 SE 2d 688 (2000); Moriarity v. Garden Sanctuary Church of God, 534

S.C. 150, 511 S.E.2d 699 (Ct. App.1999). "Because it is a drastic remedy, summary judgment should be cautiously invoked so no person will be improperly deprived of a trial of the disputed factual issues." Carolina Alliance for Fair Employment v. S.C. Dep't of Labor, Licensing & Regulation, 337 S.C. 476, 523 S.E.2d 795 (Ct. App. 1999).

CHOICE OF LAWS

Plaintiff's claim against CMC is governed by South Carolina substantive law. South Carolina's general rule governing the choice of laws is the long-standing lex loci delicti rule. Nash v. Tindall Corp., 375 S.C. 36, 650 S.E.2d 81 (Ct. App. 2007). This Latin term translates to "[t]he law of the place where the tort or other wrong was committed." Black's Law Dictionary (9th ed. 2009). South Carolina courts define the term with a bit more precision holding that the term means "the law of the state in which **the injury** occurred." Nash, 375 S.C. at 39, 650 S.E.2d at 83 (quoting Boone v. Boone, 345 S.C. 8, 13, 546 S.E.2d 191, 193 (2001))(emphasis added).[1] As discussed in more detail below, South Carolina courts' use of "injury" instead of "tort" or "wrong" helps to alleviate some of the difficulties presented in cases where the state of alleged wrongdoing differs from the state where the negative consequences of that wrongdoing are experienced.

South Carolina's version of the lex loci delicti rule has been applied in a variety of factual scenarios. For example, in a South Carolina claim by a South Carolina resident regarding a car accident occurring in North Carolina on a trip between South Carolina and New York, North Carolina substantive law applied as North Carolina was the state where the injury occurred. See Bannister v. Hertz Corp., 316 S.C. 513, 450 S.E.2d 629 (Ct. App. 1994). In Dawkins v. State, 306 S.C. 391, 412 S.E.2d 407 (1991), Georgia residents sued the state of South Carolina after an

[1] South Carolina does recognize one exception to the lex loci delicti rule. This "public policy exception" provides that "the Court will not apply foreign law if it violates the public policy of South Carolina." Nash. 375 S.C. at 41, 650 S.E.2d at 83.

escaped South Carolina Department of Corrections ("SCDC") inmate robbed their home. The Dawkins plaintiffs alleged SCDC failed to properly restrain the inmate and the plaintiffs suffered injuries as a result. Even though the alleged wrongdoing (i.e. SCDC's failure to monitor the inmate) occurred in South Carolina, the court held that Georgia substantive law applied, as Georgia was the state where the "injury" (i.e. the plaintiffs' physical/emotional injuries) occurred. Dawkins, 306 S.C. at 392, 412 S.E.2d at 408.

One of the most detailed discussions of South Carolina's lex loci delicti rule comes from Lister v. NationsBank of Delaware, N.A., 329 S.C. 133, 494 S.E.2d 449 (Ct. App. 1997). In Lister, the defendant fraudulently applied a charge to the plaintiff's credit card while the plaintiff was on vacation. The plaintiff was a South Carolina resident on vacation in Aruba when the fraudulent charge was imposed. The Court of Appeals held that South Carolina rather than Aruban law applied to the plaintiff's breach of contract accompanied by a fraudulent act claim. The injury was damage to the plaintiff's credit rating and this injury was experienced in South Carolina. For fraud or misrepresentation claims, the place of injury "is not where the misrepresentations were made but where the plaintiff, as a result of the misrepresentation, suffered a loss. Lister, 329 S.C. at 143, 494 S.E.2d at 455.

In this case, Plaintiff's claim against CMC is governed by South Carolina law as South Carolina is the state in which the injury occurred. In the Complaint, Plaintiff alleges CMC "fail[ed] to adequately consider or determine whether [redacted] could be safely discharged" to his parents, "fail[ed] to adequately recognize or adequately consider" [redacted]'s previous injuries at his father's hands, and "fail[ed] to implement...adequate additional assessment[s]" of [redacted]'s discharge to ensure he was released to a safe environment. Compl. ¶ 35(a)-(c). The Complaint also alleges that "[i]t does not appear that the CMC social worker...did anything to

ensure [redacted]'s safety" after his initial discharge from CMC. Compl. ¶ 25. After [redacted]'s discharge from CMC, "it appears [redacted] was beat [sic] mercilessly and put into a coma by the person who caused his first hospitalization in December 2009, Michael Carduff." Compl. ¶ 26. As a proximate cause of CMC's misconduct, [redacted] suffered "severe debilitating injuries which resulted in brain damage, blindness and catastrophic injuries." Compl. ¶ 36.

This is clearly a case where the place of wrongdoing and the place of experiencing the effects of wrongdoing are in different states. CMC's failure to investigate [redacted]'s family history prior to his discharge and failure to ensure [redacted] was discharged to a safe environment occurred at CMC in Charlotte, North Carolina. However, the negative effects of that misconduct, i.e. the beating [redacted] received at the hands of his father, and the permanent disabilities [redacted] must now bear for the rest of his life, have been experienced in South Carolina. CMC's conduct did not constitute the tort of negligence until [redacted] suffered damages. [redacted] did not suffer damages until he was abused by his father at the family's Rock Hill, South Carolina home. Under South Carolina's lex loci delicti rule, South Carolina is clearly the place of the injury and South Carolina substantive law applies.

ARGUMENT

1. CMC is not entitled to summary judgment on Plaintiff's negligence claim.

a. CMC owed [redacted] a duty of reasonable care.

Negligence is a "breach of a duty of care owed to the plaintiff by the defendant." Savannah Bank, N.A. v. Stalliard, 400 S.C. 246, 734 S.E.2d 161 (2012). Duty is defined as "the obligation to conform to a particular standard of conduct toward another." Nelson v. Piggly Wiggly Central, Inc., 390 S.C. 382, 701 S.E.2d 776 (Ct. App. 2010). A duty or the "obligation" to which the Nelson court referred may arise from a number of different sources. A legal duty "may be created by statute, a contractual relationship, status, property interest, or some other

special circumstance." Madison v. Babcock Ctr., Inc., 371 S.C. 123, 136, 638 S.E.2d 650 (2006). A duty may also arise by reason of the "relationship" between plaintiff and defendant. Hubbard v. Taylor, 339 S.C. 582, 589, 529 S.E.2d 549, 552 (Ct. App. 2000). Legal duties are certainly not limited to those imposed by explicit statutory enactment. See Burnett v. Family Kingdom, Inc., 387 S.C. 183, 189, 691 S.E.2d 170, 174 (Ct. App. 2010)(noting affirmative duty may be created by a statute "among other things"). A negligence claim may be based on "the common law duty to exercise reasonable care." Richland County v. Carolina Chloride, Inc., 382 S.C. 634, 647, 677 S.E.2d 892, 899 (Ct. App. 2008). The common law duty of reasonable care applies to hospitals. see Osborne v. Adams, 346 S.C. 4, 7-8, 550 S.E.2d 319, 321 (2001)(hospital has non-delegable duty of care to patients looking to hospital as institution for care/treatment); Bain v. Self Mem'l Hosp., 281 S.C. 138, 141, 314 S.E.2d 603, 605 (Ct. App. 1984)(noting hospital owed to patient "duty of exercising reasonable care"); Sloan v. Edgewood Sanatorium, 225 S.C. 1, 80 S.E.2d 348 (1954)(noting hospital "owes a duty to safeguard and protect the patient from any known possibility of self-harm or reasonably apprehended danger").

At its core, a duty arises from "the relationship between the alleged tortfeasor and the injured party." Huggins v. Citibank, N.A., 355 S.C. 329, 585 S.E.2d 275 (2003). When considering whether a duty is created by means of the parties' relationship, the courts examines the relative power and capacities of the parties. For example, a duty is more likely to be found where the plaintiff stands in an especially vulnerable position relative to the defendant. See Regions Bank v. Schmauch, 354 S.C. 648, 670, 582 S.E.2d 432, 443 (Ct. App. 2003)(considering plaintiff's claim that she was "particularly vulnerable in th[e] situation"). [redacted] a three-month old infant, is the embodiment of vulnerable individual. He was unable to defend himself from his father's abuse and unable to verbalize the danger posed by his

home environment to CMC social workers. At the time of his admission and for the entire period of his hospitalization, [redacted] looked to CMC's medical personnel and social workers to provide reasonable medical and social worker services. The relationship between CMC and [redacted] created a duty of reasonable care on CMC personnel.[2]

Even if CMC owed [redacted] no general duty of care, the hospital certainly owed a duty of reasonable care once it chose to begin providing medical and social services. A person having no affirmative duty to provide services to another may still face liability related to such services if the person voluntarily undertook a responsibility and performed that responsibility with less than reasonable care. In other words, "One who assumes to act, even thought under no obligation to do so, may become subject to the duty to act with due care." Cooke v. Allstate Mgmt. Corp., 741 F. Supp. 1205, 1209-10 (D.S.C. 1990) (quoting Crowley v. Spivey, 285 S.C. 397, 406, 329 S.E.2d 774, 780 (Ct. App. 1985)). This legal principle is codified in Restatement (Second) of Torts § 323, a section that South Carolina courts have repeatedly cited and applied. The section states as follows:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if
>
> (a) his failure to exercise such care increases the risk of such harm, or
>
> (b) the harm is suffered because of the other's reliance upon the undertaking.

South Carolina also applies Restatement (Second) of Torts § 324. See Madison, 371 S.C. at 137, 638 S.E.2d at 657. This section provides:

[2] While the existence of a duty is a legal issue, whether the circumstances of a case give rise to a special relationship between the parties may create a factual issue. Cullum Mechanical Constr., Inc. v. S.C. Baptist Hosp., 344 S.C. 423, 433, 544 S.E.2d 838, 842 (2001). Factual issues are resolved by the trier of fact and; in most instances, not on a motion for summary judgment.

One who, being under no duty to do so, takes charge of another who is helpless adequately to aid or protect himself is subject to liability to the other for any harm caused to him by:

(a) the failure of the actor to exercise reasonable care to secure the safety of the other while within the actor's charge; or

(b) the actor's discontinuing his aid or protection, if by so doing he leaves the other in a worse position than when the actor took charge of him.

[redacted] was "helpless" and was under CMC's charge during his hospitalization. Under § 323 or § 324, CMC assumed a duty to [redacted] even if no duty existed at common law.

b. CMC breached its duty to [redacted].

i. Standard of care for CMC social workers

In a negligence claim, a party breaches its duty by deviating from the applicable standard of care. The standard of care "may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines." Madison v. Babcock Ctr., Inc., 371 S.C. 123, 638 S.E.2d 650 (2006). LCH has internal policies specifically related to actions required by doctors, social workers, and other hospital staff in instances of suspected child abuse or neglect. These policies state the standard of care for the CMC personnel that treated and otherwise cared for Owen Carduff.

CMC policy PR 110.03 sets the standard of care for CMC personnel for "Juveniles Suspected of Being Abused or Neglected." CMC Policy PR 110.03, attached as **EXHIBIT 2** ("Juvenile Abuse Policy"). By its own terms, this policy is intended to set the required course of action "in cases of suspected abuse or neglect." The procedures of this policy certainly applied to Owen's December 2009 hospitalization. Three-month old [redacted] presented to LCH with two subdural hematomas. Owen was transferred to LCH due to an "apparent life threatening event." CMC History & Physical, CMC 0059-0062, attached as **EXHIBIT 3**. CMC policy requires its agents and employees to be suspicious of child abuse for any injury to a child under

six months old. See **EXHIBIT 2**, at 7 of 23. Thus, the standard of care required CMC to comply with the provisions of the Juvenile Abuse Policy in treating Owen in December 2009.

CMC's Juvenile Abuse Policy imposes several obligations on LCH doctors, social workers and other personnel in the treatment of suspected child abuse victims. First, the DSS office in the child's home county must receive notice of the hospitalization.[3] Second, LCH staff must "Complete CHS Suspected Child Abuse and Neglect form (SCAN)" for the patient and document all positive exam findings on a SCAN form. Third, there must be a consult with a "CHS Clinical Care Management Social Worker" for the purpose of conducting an "assessment process." CMC's "Child Abuse and Neglect Algorithm," a flow chart of required activities in suspected child abuse cases, also notes the requirement of a medical social worker's involvement in the assessment and treatment process. Child Abuse and Neglect Algorithm, attached as **EXHIBIT 4**. Regardless of any assessment or investigation required of DSS or law enforcement, CMC policy imposes an independent duty of assessment upon CMC social workers. CMC social worker Laura Newmark acknowledges her job entails certain assessment duties. L. Newmark Dep. 147:3-9, excerpts attached as **EXHIBIT 5**.

The psychosocial assessment must explore certain specific issues to meet the standard of care imposed by the Juvenile Abuse Policy. A CMC social worker must determine whether (1) a child's parents have caused or allowed infliction of a serious physical injury—i.e. whether the suspected victim meets the policy's definition of an "abused juvenile"; (2) parents offer a "logical explanation...consistent with the age, pattern, and severity of the injury"; (3) parents are

[3] Hospitals are statutorily required to report suspected child abuse. See N.C. Gen. Stat. § 7B-301 ("Any person or institution who has cause to suspect that any juvenile is abused ...shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found."; S.C. Code Ann. § 63-7-310(A)(requiring any "physician, nurse...or any other medical...professional" to "report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused").

guilty of any "inappropriate parental behaviors" during the child's hospitalization; and (4) whether it is safe for the child to be discharged back to the parents' care. Plaintiff's expert Dr. George Savarese, a licensed social worker, states by affidavit that there are certain "basic elements" of a psychosocial assessment performed by any competent social worker. G. Savarese Aff. at 8. These basic elements include a child's developmental history and temperament as well as characteristics of the parents including social/financial stressors, demographic risk factors (e.g. age/maturity level, educational history, and socioeconomic status), attitude toward parenting, and any relational issues between mother and father.

The Juvenile Abuse Policy not only requires CMC social workers to include certain issues in psychosocial assessments for suspected child abuse cases, it also requires the social worker to take certain actions in response to an assessment's results. The Policy is clear that a social worker must respond assertively before a child's discharge when an assessment indicates a high risk of abuse. This standard of care is distinct from the medical care provided by LCH doctors and nurses. Specifically, the policy states

> **When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS and the safety plan has been placed on the chart in writing, if applicable.**

Juvenile Abuse Policy, EXHIBIT 2 at 3 of 23 (emphasis in original); see also Algorithm, EXHIBIT 4 (same).

Based on an assessment's results, a social worker must also take efforts to prevent a vulnerable child from being placed in a dangerous environment. If an assessment shows that it is potentially unsafe for a child to be returned to his parents, the social worker should first contact DSS to see whether the department, in concert with law enforcement, will use its authority to

place the child in emergency protective custody.[4] If an assessment indicates a high risk for abuse and DSS chooses not to intervene, a CMC social worker has a duty to exercise the authority granted by North Carolina law to seek a court order to retain temporary custody of a suspected abuse victim. See N.C. Gen. Stat. § 7B-308.The use of this statute is part of the general duty to use reasonable care in rendering of services to a child. Though a North Carolina Statute, it is what a reasonable hospital and its employees and agents would use in discharging care to a child.

ii. CMC social workers deviated from the standard of care.

CMC social workers breached the standard of care in their assessment, communication, and efforts to intervene on behalf of [redacted] G. Savarese Aff. at 7. CMC social workers Katie Harrison and Laura Newmark combined to conduct a psychosocial assessment ignoring issues CMC policies required them to address and issues any competent assessment would include. Katie Harrison was the weekend social worker who initially worked on Owen's case on December 5th and 6th. Social work's duties were then handed over to Laura Newmark, LCH's weekday social worker. Between these two social workers, the psychosocial assessment of Owen's care totals just six quarter-page entries in Owen's medical record. See CMC 0092-0097, attached as **EXHIBIT 6**. The assessment's brief entries contain "minimal" information and "do[] not explore or probe any of the areas that a competent psychosocial assignment should." G. Savarese Aff. at 9. Plaintiff's experts also note a deviation from the standard in the way in which Ms. Harrison and Ms. Newmark handled the transition from the weekend to the weekdays. Ms. Newmark's entries in the assessment make clear that she simply "rubberstamped" Ms. Harrison's bare-bones assessment while failing to ask the necessary questions to address the family's abuse risk profile. Id.

[4] Emergency protective custody allows the state to take physical custody of a child for "a temporary period of no more than twenty-four hours to protect the child from imminent danger." S.C. Code Ann. § 63-7-20(9).

The social workers' assessment lacked the breadth and rigor the standard of care required. Ms. Newmark described her investigation of [redacted]'s subdural hematoma as limited to "tak[ing] a history from the parents on [whether] there [had] been any recent trauma." L. Newmark Dep. 36:5-9. The tough yet vital questions were not asked of [redacted]'s parents. For those instances where questions were asked, the social workers were overly deferential to the parents' answers. Ms. Newmark viewed her assessment duty as nothing more than obtaining the parents' "story" regarding the source of the injury and the child's history. See L. Newmark Dep. 162:16-163:2. According to Dr. Savarese, a competent social worker would interview parents and then investigate their claims rather than simply acquiring and accepting a parent's explanation. G. Savarese Aff. at 7.

Ms. Harrison and Ms. Newmark had at their disposal many different options to conduct a competent psychosocial assessment. The social workers should have interviewed extended family members including the paternal grandparents and father's step-brother who could have provided additional context to understand the home environment to which CMC released [redacted] Id. at 19. There is no indication that the social workers requested police or prior treatment records for [redacted] or his parents. Id. Social workers also typically use standardized child abuse screening tools and other "risk assessment instruments" to aid in the assessment process. CMC social workers should have employed these devices in [redacted]'s case. Id. at 20.

The assessment breaches contributed to the social workers' failure to comply with their communication duties. The other participants in [redacted]'s case (DSS and law enforcement) "depend upon the hospital's assessment of risk, which is based on a combination of both medical and psychosocial data." Id. at 29. DSS would have considered input from hospital sources in making DSS case decisions including "any concerns that they have." K. Hinnant Dep. 26:6-12,

excerpts attached as **EXHIBIT 7**. Ms. Newmark acknowledges CMC had a duty to "report to DSS" and "provid[e] them with up-to-date information." L. Newmark Dep. 35:20. However, by conducting an incomplete, surface level psychosocial assessment, the CMC social workers were not in a position to make the required communications. G. Savarese Aff. at 23. In sum, the social workers were required to "communicate accurately the potential risk of harm to the child" posed by the parents or parental home environment. Ms. Harrison and Ms. Newmark did not make the required communications on this "family risk profile." Id. at 23.

The Juvenile Abuse Policy and Plaintiff's experts establish that CMC social workers had a clear responsibility related to a patient's discharge. Ms. Newmark fails to acknowledge these duties, claiming her responsibility was to be "a liaison between the medical team and DSS." L. Newmark Dep. 10:24-11:1. Social workers were required to be part of the process in determining [redacted]'s disposition. Juvenile Abuse Policy, at 3 of 23. Ms. Newmark's efforts to disavow these responsibilities are concerning from a hospital policy and hospital administration perspective.

Plaintiff's hospital administration expert J. Kevin Moore notes deviations from the standard of care in the efforts of Ms. Newmark and other CMC agents to deem their actions as reasonable simply because non-accidental trauma was not conclusively established by medical tests. K. Moore Aff. at 3-4, attached as **EXHIBIT 8** ("medical clearance is not synonymous with 'ready for discharge' and cannot be treated as such under LCH policy"). Dr. Cheryl Courtlandt, [redacted]'s treating physician, made clear at her deposition that [redacted]'s medical tests did not eliminate the possibility that [redacted] was abused. Dr. Courtlandt testified that some elements presented concern for non-accidental trauma. As a whole, "it could not be determined whether or whether not he had been the victim of child abuse." C. Courtlandt Dep. 45:13-21, excerpt attached as **EXHIBIT 9**. Additionally, the Juvenile Abuse Policy makes clear, medical

substantiation is only one factor a hospital must consider when determining the conditions of a child's discharge. In circumstances like these, CMC agrees that it should err on the side of caution. C. Courtlandt Dep. 41:1-13. By failing to intervene at [redacted]'s discharge when they knew or should have known the medical tests could not rule out non-accidental trauma, CMC social workers failed to err on the side of caution. K. Moore Aff. at 6 (hospital "failed to take actions which would or could have averted subject exposure to and possibilities for ongoing abuse").

CMC social workers' voices were required in the discharge decision making process. They had a duty to participate in both the development and implementation of a safe discharge plan for [redacted]. G. Savarese Aff. at 26. An adequate psychosocial assessment of [redacted]'s history and his parents would have led a competent social worker to realize the high risk of maltreatment posed by the environment to which [redacted] was to be released. Even CMC's substandard assessment led to some suspicions of abuse as indicated by CMC's decision to post a sitter in [redacted]'s room. K. Moore Aff. at 3-4. Yet, when the time came for the social workers to intervene so as not to place [redacted] back into the unsupervised custody of his parents, CMC failed. There were many available options the social workers could have recommended including relative placement, supervised parental visitation, and a delay in discharge. G. Savarese Aff. at 26. Additionally, the hospital was empowered by law to seek emergency temporary custody of Owen to prevent his release to a high-risk environment. Just as they had in their duties to assess and communicate, CMC personnel failed in their duty to intervene on behalf of the three-month old child in their care.

c. CMC's conduct proximately caused [redacted]'s damages.

Proximate causation is an essential element of any negligence cause of action. Burnett v. Family Kingdom, Inc., 387 S.C. 183, 191, 691 S.E.2d 170, 175 (Ct. App. 2010). This element requires proof of both "causation in fact and legal cause." Small v. Pioneer Mach., Inc., 329 S.C. 448, 463, 494 S.E.2d 835, 842 (Ct. App. 1987)(citing Hurd v. Williamsburg County, 363 S.C. 421, 428, 611 S.E.2d 488, 492 (2005)). Causation in fact is established by proof that the injury "would not have occurred but for the defendant's negligence." Cody P. v. Bank of Am., N.A., 395 S.C. 611, 620, 720 S.E.2d 473, 478 (Ct. App. 2011)(citing Mellen v. Lane, 377 S.C. 267, 278, 659 S.E.2d 236, 245 (Ct. App. 2008). Legal cause is established by determining foreseeability, a factor which focuses on "whether the injury is the natural and probable consequence of the alleged negligent act." Id. As the Cooke court noted, "[p]roximate cause is generally a question for the jury." 741 F. Supp. at 1214; see also Ballou v. Sigma Nu Gen. Fraternity, 291 S.C. 140, 147, 352 S.E.2d 488, 493 (Ct. App. 1986)("Only in rare or exceptional cases may the question of proximate cause be decided as a matter of law"). Summary judgment on proximate cause is inappropriate where the plaintiff has produced "some evidence." Cooke, 741 F. Supp. at 1214.

In this case, CMC social workers breached the standard of care applicable to their assessment, communication, and intervention. As a direct and proximate result of those breaches, [redacted] has suffered severe brain injuries and impairments with which he must deal for the rest of his life. The "causal chain" leading to [redacted]'s current condition started with the grossly insufficient psychosocial assessment performed by CMC social workers. G. Savarese Aff. at 30. A competent assessment would have contained information CMC was under a duty to communicate to [redacted]s medical team, DSS, and law enforcement. There was pertinent

information easily available to Ms. Harrison and Ms. Newmark had they properly performed their assessment responsibilities. Id. at 11. This is evident from the information obtained when a fuller inquiry was undertaken after the January 2010 injury. Michael Carduff acknowledged that his relationship with Kayla was strained since [redacted]'s birth, Kayla acknowledged Michael's poor parenting skills and apathy toward [redacted], and the maternal grandmother reported stress between the grandparents and Kayla regarding Michael's conduct and disposition toward [redacted]. Id. at 11-14.

A proper assessment would have revealed these facts and would have been included in the information communicated to other decision makers and used by the social workers in meeting their duty to decide on the disposition of the patient. Instead, "dangerously inaccurate information was communicated, beginning with the hospital's social worker's deficient assessment of the psychosocial risk factors and her lack of comprehension of the resulting inherently high-risk of potential harm to the child." Id. at 30. CMC social workers not only failed to acquire needed information during their assessment, they also failed to properly construe the evidence right before their eyes. [redacted] was admitted to LCH with a subdural hematoma for which his parents could not offer a satisfactory explanation. While medical tests for non-accidental trauma were inconclusive, construing these results as conclusive evidence of an accidental injury is not a reasonable response. The night before [redacted] was discharged, CMC neurosurgeon noted [redacted] was, from a medical perspective, ready for discharge but only "under supervision." CMC 0039, attached as **EXHIBIT 10**.

Had this information been collected, properly analyzed, properly communicated, and properly utilized in December 2009, [redacted] would not have been discharged to his parents without supervision. Instead, he would have been taken into emergency protective custody by

South Carolina authorities, remained at LCH under the procedures outlined in North Carolina law, or discharged to some caregiver other than his parents. More likely than not, Owen would not have been in Michael Carduff's custody in January 2010 when Michael inflicted the injuries from which Owen currently suffers. See G. Savarese Aff. at 30 (concluding that but for CMC's standard of care breaches "it is more likely than not this child would have been placed into custody with some other person than the custodial parents and the tragic situation in January 2010 would have been avoided").

Plaintiff anticipates CMC may claim any chain of causation between its conduct and [redacted]'s injuries is severed by the intervening criminal act of Michael Carduff, an individual over which CMC lacks control. However, the intervening criminal act of a third party does not automatically sever the causal chain between a defendant's negligent conduct and a plaintiff's injuries. In fact, "where the injury at the hand of the intervening party was within the general range of consequences which any reasonable person might foresee as a natural and probable consequence of the negligent act," then the defendant remains a proximate cause. Shepard v. S.C. Dep't of Corr., 299 S.C. 370, 375, 375 S.E.2d 37, 37 (Ct. App. 1989). Plaintiff need not prove the "particular chain of events" was foreseeable but only that the injury the criminal inflicted was "within the general range of consequences which any reasonable person might foresee." Cody P., 395 S.C. at 621, 720 S.E.2d at 478 (citing Shepard 299 S.C. at 375, 385 S.E.2d at 38). It was very foreseeable that allowing [redacted] to be returned to the care of the person(s) most likely responsible for causing the brain injury diagnosed on December 5, 2009 would lead to further injury or even death.

Several different types of evidence may be used to demonstrate that a defendant could reasonably foresee injuries ultimately perpetrated by the criminal act of an independent third

party. Expert testimony may be used to establish foreseeability. An expert with knowledge of the defendant's business may testify regarding the types of harms the defendant anticipates in its business. See Cody P., 395 S.C. at 621-22, 720 S.E.2d at 478 (considering banking expert's testimony that banks anticipate theft). The defendant's policies and procedures may also demonstrate that it foresees certain types of harms may flow from its negligent conduct. In Cody P., the defendant's policies and procedures established rules to guard against certain harms. Id. at 622, 720 S.E.2d at 478. The policies themselves were some evidence that the defendant foresaw the types of harms it took the time and effort to guard against. Id.

Child abuse at the hand of a child's parent lies at the core of what the Juvenile Abuse Policy is designed to prevent. Before a child is discharged from the hospital, the Policy requires consideration of whether "it is unsafe for the juvenile to return to his or her parent." **EXHIBIT** , at 3 of 23. Competent social workers in the position of Ms. Harrison and Ms. Newmark recognize that their work is designed to prevent caretaker abuse of vulnerable children. They also recognize the risk of child abuse associated with "plac[ing] the child under the control of the two primary suspected potential perpetrators." G. Savarese Aff. at 29. Michael Carduff's January 2010 conduct was foreseeable to CMC and does not break the chain of causation between CMC's negligence and [redacted]'s injuries.

2. CMC is not entitled to immunity under S.C. Code Ann. § 63-7-390.

The South Carolina Children's Code requires certain classes of individuals to report instances of suspected child abuse or neglect to DSS or law enforcement. S.C. Code Ann. § 63-7-310(A), (D). The duty to report applies to any "physician," "nurse," "medical...professional," and "social or public assistance worker." Id. An individual subject to § 63-7-310's duty who fails to report suspected abuse or neglect may face criminal liability. S.C. Code Ann. § 63-7-410. The

Children's Code also confers immunity on mandatory reporters for civil and criminal liability arising from the performance of their reporting duty. S.C. Code Ann. § 63-7-390. CMC claims the immunity provision entitles it to summary judgment on Plaintiff's negligence claim. However, the conduct underlying Plaintiff's claim does not fall within the immunity's scope and summary judgment on this basis must be denied.

To embolden various professionals interacting with children to meet their statutory obligation and help DSS/police address the public welfare problem of child abuse and neglect, immunity is provided for claims related to a report of suspected child abuse. The immunity provision's limited reach is clear from its language. Under § 63-7-390, a "person required or permitted to report...is immune from civil and criminal liability which might otherwise result by reason of these actions." The proper construction of this statute clearly indicates that immunity is limited. See In re Campbell, 379 S.C. 593, 599-600, 666 S.E.2d 908, 911 (2008)("The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature"). Legislative intent "should be ascertained primarily from the plain language of the statute." Thompson v. Cisson Constr. Co., 377 S.C. 137, 157, 659 S.E.2d 171, 181 (Ct. App. 2008). The statute's plain language indicates the immunity is limited to "these actions," i.e. actions described and mandated by § 63-7-310 and other provisions within the same article of the Children's Code.

This immunity provision is not intended to provide reporters blanket immunity for post-report conduct. Recognizing the statute's plain language, the South Carolina Attorney General's office has concluded the immunity applies only "for reports made of abuse or neglect." Op. S.C. Att'y Gen. 06-22 (Jan. 26, 2006); see also Op. S.C. Att'y Gen. 04-6 (Jan. 7, 2004)(statute provides immunity for reporter "by reason of his or her reporting in good faith" suspected

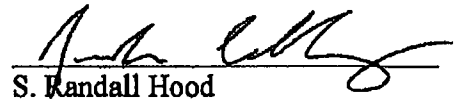
effective reporting system and encouraging the reporting of children in need of protection." See Op. S.C. Att'y Gen. (June 22, 1990). Conferring immunity to CMC for alleged violation of its common law and internal policy duties to assess a patient's potential discharge environment does nothing to protect children or encourage reports of suspected child abuse.

Reporter immunity is designed to prevent claims against a reporter based on the report's veracity or the reporter's motivation. The statutory language supports this view in that it includes a rebuttable presumption of good faith. To support the statutory goal of encouraging reports of even "suspected" child abuse, the legislature grants reporters immunity from defamation, emotional distress, and privacy tort claims for good faith reports and further installed a presumption of good faith. See Williams, 379 S.C. at 532, 665 S.E.2d at 244 (applying reporter immunity to defamation and intentional infliction of emotional distress claims). This strikes the proper balance between encouraging reports and preventing vindictive, bad faith reports. In sum, Plaintiff's negligence claim against CMC does not allege conduct covered by the reporter's immunity and the immunity provision does not apply to this case.

CONCLUSION

Based on the arguments stated above, Plaintiff respectfully requests that the Court deny CMC's Motion for Summary Judgment. Plaintiff has presented competent evidence on all required elements of her negligence claim against CMC. Additionally, CMC is not entitled to immunity under S.C. Code Ann. § 63-7-390.

Respectfully submitted,



S. Randall Hood
Lara Pettiss Harrill
Deborah G. Casey
Jordan C. Calloway
McGowan, Hood & Felder, LLC

1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
(803) 328-5656 (fax)
rhood@mcgowanhood.com
lharrill@mcgowanhood.com
dcasey@mcgowanhood.com
jcalloway@mcgowanhood.com

April 17, 2013
Rock Hill, South Carolina

In re: Elizabeth Hope Rainey (Guardian Ad Litem to [redacted]) v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center (CMC), et. al.

Prepared by: George W. Savarese, PhD, LCSW
637 East Golf Road, Suite 201
Arlington Heights, Illinois 60005
847-791-1950 phone
817-549-6460 efax

Note: This affidavit with findings is propounded with a focus on the hospital social workers' role in [redacted]'s care during the December, 2009 hospitalization, in order to determine if those actions were consistent with the applicable standards of care along the dimensions of Assessment, Communication, Intervention, and Documentation. A second affidavit can be propounded with a focus on DSS and Law enforcement actions in regard to the investigation, care and diligence of the state agencies in regard to their actions or inactions concerning [redacted].

Section I outlines the basic facts of the case. Section II identifies the applicable standards of care with regard to the social workers' actions. Section III outlines the deviations from those standards of care with supporting documentation in the case record. Section IV provides a conclusion.

I. Summary of Facts of Case

On December 5, 2009, [redacted], a 3-month old infant child, was brought by car by his parents to Piedmont Medical Center after going "limp" in his father's arms shortly before the child's mother returned home from work. The child was later transferred to Carolinas Medical Center (CMC) where he was subsequently admitted. A CT scan revealed subdural hematomas that raised the suspicion of non-accidental trauma. Medical and psychosocial assessments were conducted by the hospital. While the child was still hospitalized, a referral to the Department of Social Services (DSS) was initiated to investigate the case. Unable to conclusively rule out non-accidental trauma, on December 8, 2009, the child was discharged back to the parent's home under their supervision. On January 11, 2010, the child returned to CMC having sustained more severe injuries.

II. Applicable Standards of Care

The following documents embody the practice standards, guidelines, and indicators reflecting the applicable standards of care related to the social workers' actions within the context of the hospital's multi-disciplinary team:

> *National Association of Social Workers (NASW) "Code of Ethics" (2008)*
>
> *National Association of Social Workers (NASW) "Standards for Clinical Social Work in Social Work Practice" (2005)*
>
> *National Association of Social Workers (NASW) "Standards for Social Work Practice in Health Care Settings" (2005)*
>
> *National Association of Social Workers (NASW) "Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital" (1990)*

The specific standards are outlined below, grouped by the domains of Assessment, Communication, Intervention, and Documentation corresponding to the key areas upon which the findings of this evaluation are based, as outlined in Section III.

ASSESSMENT

NASW Code of Ethics
Section 4.01: Competence

> Social workers should strive to become and remain proficient in professional practice and the performance of professional functions.

NASW Standards for Clinical Social Work in Social Work Practice
Standard 2: Specialized Practice Skills and Interventions

> Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical interventions with individuals, families, couple, and groups...They shall be familiar with social, psychological, cultural, and health factors that influence the mental, emotional, and behavioral functioning of the client...They shall have the ability to gather and interpret social, personal, environmental, and health information... evaluate and treat problems within their scope of practice... [and] collaborate effectively with other social workers or allied professionals, when appropriate... They shall be accountable for all aspects of their professional judgment, behavior, and decisions.

Pre-revised Version (1989 to 2005): Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions... including the ability to ...obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis.

NASW Standards for Social Work Practice in Health Care Settings
Standard 5: Knowledge

Social workers in health care settings shall demonstrate a working knowledge of current theory and practice and integrate such information into practice...Essential areas of knowledge and understanding about health care include: the biopsychosocial needs of clients and families, the psychological... needs of clients and families and how to ensure that they can be addressed.

NASW Standards for Social Work Practice in Health Care Settings
Standard 6: Assessment

Social workers shall provide ongoing assessment, including gathering comprehensive information to use in developing interventions and treatment strategies.

COMMUNICATION

NASW Code of Ethics
Section 2.03: Interdisciplinary Collaboration

Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that effect well-being of client's by drawing on perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established...Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels.

NASW Code of Ethics
Section 2.05: Consultation

Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interest of clients.

NASW Standards for Social Work Practice in Health Care Settings
Standard 11: Teamwork and Collaboration

> Social workers shall participate in care teams and collaborate with other professionals, volunteers, and groups in and outside of their practice setting to enhance all aspects of the client and family system's care...Social workers participate in multiple care teams, which are typically interdisciplinary. As part of such teams and collaborations, social workers shall demonstrate the ability to...ensure that the social work role and responsibilities are clearly delineated and communicated to other members of the team.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 5: Teamwork

> Patient discharge occurs with the knowledge of the social worker coordinating discharge planning...Social workers are responsible for coordination of patient's discharge plans, especially when post-hospital care is required.

INTERVENTION

NASW Code of Ethics
Section 1.16: Termination of Services

> Social workers should terminate services to clients...when such services are no longer required or no longer serve the client's needs or interests...Social workers should take reasonable steps to avoid abandoning clients who are still in need of services... [should give] careful consideration to all factors in the situation [and] taking care to minimize possible adverse effects... [and] should assist in making appropriate arrangements for continuation of services when necessary.

NASW Code of Ethics
Section 2.06: Referral for Services

> Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional

service is required...Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

NASW Standards for Clinical Social Work in Social Work Practice
Standard 3: Referrals

Clinical social workers shall be knowledgeable about community resources and make appropriate referrals, as needed...They shall maintain collaborative contacts with social work or other related professionals and make appropriate referrals, as needed.

Pre-revised Version (1989 to 2005): Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients...When a client is being served by other agencies, the clinical social worker shall maintain collaborative contacts as necessary with the other providers to ensure the coordination of services and the client's receipt of optimal benefits from the various services...When the client is involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility.

NASW Standards for Social Work Practice in Health Care Settings
Standard 7: Intervention and Treatment

Social workers implement intervention and treatment plans that promote client well-being and ensure a continuum of care. Planning shall be based on a comprehensive, culturally-competent assessment with interdisciplinary input...Intervention and treatment plans include strategies to address needs identified in the assessment...discharge planning...[and] client and systems advocacy.

NASW Standards for Social Work Practice in Health Care Settings
Standard 10: Client and Community Education

Social workers act as educators for clients, families, the community, and other professionals regarding disease prevention, impact of the illness and disease progression, advocacy for benefits, health maintenance, and adherence to treatment regimens...Assessment identifies the educational needs based on the expressed needs of individuals, family members, and significant others. The social worker identifies deficiencies in the

knowledge base of the client and works with the client to obtain the needed information and resources.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 6: Readmissions with Social Complications

Patients are readmitted with social complications. Social workers are responsible for ensuring that patients receive the immediate post-hospital care they need and adapt to the post-hospital setting. Readmission of too many patients due to social complications suggests either that they did not receive social work services or that these services were inadequate.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 1: Follow-Up

Patient discharge care is assessed following discharge. Patients who are at high risk for developing problems with post-discharge care should receive a follow-up assessment after discharge to determine whether the aftercare plan is being implemented as planned.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 2: Problem Resolution

Patient's medically related psychosocial problems are ameliorated. The intent of social work intervention is to improve or resolve patients' psychosocial problems related to their medical care. Problem improvement or resolution is an indicator of whether the intervention has achieved its goal.

DOCUMENTATION

NASW Standards for Clinical Social Work in Social Work Practic,
Standard 8: Documentation

Documentation of services provided to, or on behalf of, the client shall be recorded in the client's file or record of services...Documentation must reflect an accurate account of services. Progress notes, reports, and summaries of services shall be regularly recorded in the client's file.

III. Specific Deviations from Standards of Care

The specific deviations from the above standards of care by CMC employees (with a specific focus on the hospital social workers) can be understood as occurring in four primary domains: Assessment, Communication, Intervention, and Documentation. These deviations include the following:

ASSESSMENT

Failure to conduct an independent, appropriate, and complete psychosocial assessment within the institutional hospital setting

- [Did you make any clinical assessment of either parent to determine if either were a risk of being or becoming abusers of their child?] "My interaction with them [the parents] would have been more brief than Katie's [Katie Harrison, MSW] was...because their story about the admission would have already been told and DSS would have already been involved, so generally we don't continue to ask them to share the story over and over again." [NEWMARK 162:20]

  Comments: It is clear that the social worker believes that her assessment is limited to simply obtaining the parents' "story" of what happened. This grossly minimizes the critical social work role of conducting a comprehensive psychosocial assessment, which includes assessing the risk potential for harm to the child in order to facilitate a safe discharge. The purpose of the psychosocial assessment is to gain a thorough understanding of the factors that may contribute to circumstances or conditions which could reasonably result in abuse/neglect or a significant risk of harm to the child. From a continuity of care perspective, by reading the weekend social worker's note [Katie Harrison, MSW], Ms. Newmark should have seen that the information contained in that initial assessment was minimal and that further assessment was necessary in this regard.

- CMC Policy & Procedures indicate that in cases with juveniles suspected of being abused or neglected the clinical team must "Consult CHS (Carolinas Healthcare System) Clinical Care Management Social Worker to aid in the assessment process...Utilize your hospital MSW's during regular business hours." [NEWMARK Exhibit 10]

  Comments: Based on the hospitals own policies and procedures, the social workers role and responsibility to conduct a comprehensive psychosocial assessment are clearly outlined.

- "The presence of risk factors should not be used as indicators of child abuse but rather to provide guidance in prevention strategies as well as management and treatment plans." [COURTLAND Exhibit 14] ["A careful and well-documented history is one of the most critical elements of the medical evaluation, right?] "Yes." [COURTLAND 90:18]

  Comments: *It is the role of the social worker to assess the presence of psychosocial risk factors in the patient's past and present history that are used to develop the risk profile in conjunction with the medical evidence. Factors which constitute the basic elements of a psychosocial assessment (which is the specific purview of the social worker), include a developmental history, pregnancy history, familial patterns of discipline, the child's temperament, social and financial stressors, demographic risk factors, parental attitudes, marital/relational issues, etc. The risk profile is then used to guide the discharge plan with regard to the level of precaution necessary to protect the child from harm. The social worker doesn't have to "solve the case" regarding abuse, per se. The social work role is to assess and comprehend the risk profile then communicate to the hospital multi-disciplinary team and outside agencies the proper degree of inherent risk based on the psychosocial assessment.*

- Laura Newmark, MSW, and Katie Harrison, MSW were the two key hospital social workers involved in the case. Ms. Harrison, the weekend social worker, has a total of 4 progress notes (dated12/06/09). Taken together, they comprise her entire psychosocial assessment. Ms. Newmark has 2 progress notes.

  With regard to Katie Harrison's assessment, the relevant psychosocial information in her 4 progress notes (dated 12/06/09) includes: "...parents do not have a home phone...Parents report that on Wednesday (12/02/09) parents noticed...baby...screaming non-stop...patient...went limp but was still breathing...patient has blood on the right side of his brain...Parents deny any trauma, that anyone dropped the baby, patient's birth was normal, full-term. Baby is only watched by parents and maternal grandmother, no daycare...baby does have South Carolina Medicaid, WIC, mom has food stamps...Both parents work... Maternal grandmother watches baby when parents are working...RN Sara did report that maternal grandmother did tell her privately that when she had picked up baby from dad and uncle that she noticed baby had a bump on his head, she asked dad and uncle about this and dad and uncle stated they had no idea why this happened...MSW will follow as needed." [NEWMARK Exhibit 1]

With regard to Laura Newmark's assessment, the relevant psychosocial information in her 2 progress notes (dated 12/07/09) includes: "...anticipate discharge hopefully this date. Owen lives with parents, no other children, does have Medicaid, WIC, transportation, frequent babysitting with maternal grandmother. Both parents employed, father has finished 10th grade, mother 11th. MSW discussed safe sleeping, other parenting education available for parents prior to discharge...will follow for safe discharge plan. Updated RN, MD." [NEWMARK Exhibit 1]

Comments: In effect, Ms. Newmark "rubberstamped" Ms. Harrison's assessment. She did not add any additional information to the chart that addressed the risk profile. Essentially, both social workers abrogated their professional duty to conduct a competent comprehensive psychosocial assessment, essentially leaving the task to be done by DSS. The information contained in the total of 6 progress notes is minimal and does not explore or probe any of the areas that a competent psychosocial assessment should, particularly in a case involving potential child abuse. This is not to say that it was not appropriate for DSS to conduct their own investigation of the case, but rather to point out that the hospital social workers have a duty to conduct a comprehensive independent psychosocial assessment as well. Despite the fact that the psychosocial assessment did not address the necessary areas, the information that was contained in the social work progress notes and in the patient's medical chart contained enough facts that indicated a high risk of harm to the child which was not recognized by the social workers. These facts are listed below.

Failure to comprehend the high-risk profile for child abuse despite the presence of numerous evidence-based clinical markers

Markers that were identified in the social workers psychosocial assessment based on interviews with parents and a review of the medical chart:

- The medical findings of subdural hematomas (bleeding of the brain) that could not be explained medically
- The possibility of non-accidental trauma could not be conclusively ruled out
- Parental explanations that did not adequately explain the injury [COURTLAND 35:7]
- A delay of 8-10 minutes to do anything at all when they thought the child "was dead" and "went limp". "Owen lethargic, not responsive and we thought he was dead." [DSS 00143]

- No call to 911/ambulance, instead driving the child to ER *(The parents had no home phone but did have a cell phone; they said they "thought it would take too long for the ambulance to arrive.")*
- No witnesses to corroborate father's story
- Father was the last person alone with the child when the injury occurred
- Adolescent, unmarried parents
- Low socioeconomic status of parents
- Low education level of parents
- An unidentified babysitter was reported to have been involved with the child on the Thursday preceding the injury
- Child "screaming non-stop"; "crying incessantly", "irritable", "fussy"; "increased crying episodes" [COURTLAND 34:8; 98:7] in weeks preceding injury *(An inconsolable child is a classic trigger for child abuse.)*

  Comments: These factors noted above, when considered together, should have served at a minimum, to reflect a risk profile consistent with the strong possibility of child abuse. As such, the need for safety precautions should have been regarded as high from the point of admission. Given the risk profile noted and the fact that non-accidental trauma could not be definitively ruled out, the social workers should have erred on the side of caution in the discharge planning process.

- "I don't think we can predict the future on what is or what isn't going to happen in working with DSS." [NEWMARK 84:21]

  Comments: This is the very reason why the standard of care in practice is to err on the side of caution, which was not done in this case.

- "I don't agree that the parents were suspected [of child abuse]. A report was made and in terms of erring on the side of caution, we'd rather make the report to DSS than not and hope that DSS can do a complete follow-up that we can't do here in the hospital." [NEWMARK 125:19]

  Comments: How the social worker could not agree with the fact that the parents were suspected of abuse is difficult to understand. The fact that the physicians could not rule out NAT by default indicates that there was still a suspicion of abuse. The problem is that the social worker herself did not recognize this inherent risk and diminished it to the extent that all of her subsequent involvement in the case was predicated on this perception of diminished risk. Additionally, there was no reason that the social worker was unable to do a competent psychosocial assessment in the hospital. Given a four day hospitalization and full access to the family, the social worker had more than ample opportunity to interview the principle persons involved. Although assessing the home environment was

important, it was not necessary to formulate an appropriate discharge plan given the risk profile presented in the hospital. The social worker simply deferred her professional responsibilities to DSS.

Markers that were not known due to lack of probing/exploring in interviews with parents and other available collateral sources:

If the parents were independently assessed properly by the social workers (and/or DSS), collateral sources were interviewed, records were obtained, and standardized instruments were utilized, the following additional information would potentially have been elicited, indicating even a higher degree of risk in sending the child home to the parents:

Information available from Michael Carduff (father)

- "In the past, I would get frustrated with [redacted]'s crying and pat him in the back hard." [DSS 00176]

  Comments: Michael admitted this to the detective after the second hospitalization. If properly interviewed by the social workers, this information may have been recognized.

- "Since [redacted] came along mine and Kayla's relationship has been a little stressed." [DSS 00179]

  Comments: The relational stress is noted.

- Michael told police he was charged with possession of stolen goods at age 16...Michael said that since [redacted] came along, things have been a little stressed... Michael told police he was charged with possession of stolen goods at age 16..." [SHER 000027-28]

  Comments: Relational stress and a criminal history are risk factors for child abuse.

Information available from Kayla Lythgoe (mother)

- "Like any typical man, Michael never wanted to change diapers...he did get nervous when he had to be alone with him [[redacted]...After he'd burp him and couldn't figure out [how to stop him from crying] he'd usually just bring him to me...Michael lost his job just after [redacted] was born...[Kayla's mother] did not hold [Michael] in high regard...[Charlotte's attitude] created "a little" stress between [us]...Michael would be rough with [redacted], picking him up, forget to support his head, swoop him up super fast, at

two months he would do up and down [bouncing him on his knee] with him...I was worried about it. It just scared me...he wasn't aware of how fragile a child could be...[[redacted] could not turn over and hit the side of the crib because]...he was not that advanced...Michael not working at Food Lion after October [2009] became a source of stress for us...[Michael lost his job after he] "never went back" [one day that he took off to see his parents]...Michael would complain that he hated his manager and that the manager hated him...After getting fired, Michael never looked for a job. He got very lazy...I would yell all the time and he'd yell at me for being a nag...Michael got frustrated over [Kayla] nagging him about not working...He was always playing video games all day...[The week before 12/04/09, [redacted] had been acting weird...it was constant crying...crying, crying, crying....[redacted] was more of a bother than a good thing when [Michael's] friends were over...[Arguments would occur about] ...you're not showing any incentive of being a man, you're being lazy, you're friends are always here, this is not a party house..." [LYTHGOE 41:12-13, 41:21-23, 42:12-16, 43:4-6, 43:7-9, 43:12-25, 44:3-23, 45:16-18, 47:4-9, 47:12-20, 48:9-11, 50:4-9, 50:20-22, 57:7-8, 57:17-21, 62:23-24, 64:20-21, 87:7-18]

Comments: The information obtained in Kayla's deposition was available to the hospital social worker if a proper assessment was conducted in a proactive manner. The facts stated by the child's mother clearly reflect a wide number and range of familial stressors and risk factors for potential abuse of a child, particularly a classic trigger for abuse, the non-stop crying. All of this information was available for consideration by the social worker, the hospital team, DSS, and law enforcement had a competent psychosocial assessment been completed, then communicated to the appropriate collateral agencies.

- A psychological evaluation of [redacted]'s mother, Kayla, conducted after the child was re-injured in January, 2010, indicates that her mother (Charlotte Williams, the child's grandmother) was married three times, Kayla witnessed physical abuse of her mother at the hands of her father on a weekly basis till around age 11, that Kayla was very immature emotionally, had poor insight and judgment, excessive dependency issues with men, and was diagnosed with Dependent Personality Disorder. [DEF PROD 00219-227]

  Comments: The implications of these findings suggests a higher risk for the child, especially given the mother's propensity to possibly "look the other way" given her emotional needs and deficits. This is critical information that could have been elicited by the social worker either by a direct, more in-depth interview, or by simply making a psychological

referral to administer some basic surveys or psychological testing, given the suspicion of abuse.

- [Kayla stated regarding the mark her mother [Charlotte Williams, [redacted]'s maternal grandmother] observed in November, 2009]: "Michael said he hit himself with some keys (toy). It was on a Saturday and both she and her mother were upset about this incident. She was upset at MGM for asking questions about the baby having scratches/marks when she did not know where they came from." [DSS 00247]

  Comments: The noted presence of a bruise observed just prior to the recent injuries is a marker for abuse.

- "[redacted] behavior changed on 11/28/09. He was sleeping a lot and screamed when awake, non-stop...The week before 12/04/09 the child was crying a lot." [DSS 00236]

  Comments: This is a classic trigger for SBS. Had this been assessed, the risk would have been understood.

- "Kayla has no bonding with [redacted], does not ask questions, plays with his toys." [DSS 00237]

  Comments: If the maternal relationship with the child had been explored in more depth, this information may have been available.

- "Kayla is back and forth (from the hospital) and she usually does not bond with the child...MGM is the only one there (at the hospital) with the child...the child needs to be in foster care and the foster care parent needs to be the one at the hospital instead of the family." [DSS 00251]

  Comments: Why wasn't a parental bonding evaluation (or other surveys) done at the first hospitalization to look at these types of issues in determining the safety of DC home to parents in the face of the suspected NAT/SBS?

- "Kayla could not determine what happened to [redacted] in December. Kayla never paid attention to the marks. Kayla depends on her mother to make decisions for the child. Kayla appears immature. She does not bond with [redacted] and usually sleeps the entire time." [DSS 00237]

  Comments: Additional Important Information.

- [Regarding discipline]: "When Kayla becomes frustrated she calls her mother."[DSS 00248]

  Comments: Reflects the immature dependency on her mother, which in turn reflects a higher degree of risk for returning the child home without a proper safety plan.

- "...[S]ometimes Michael picks up [redacted] too quick or handles him too rough, I have to tell him to be easy...Michael never got up with [redacted] or helped with him unless I asked...It seems that everything happened bad to [redacted] that he was in Michael's care...[My] mother never liked Michael and that she disliked how he looked...he was lazy and a kid and that she could do better...I think if we had gotten the parenting classes that this may not have happened...Michael never talks to the baby at home." [SHER 000019-23]

  Comments: This information was elicited by the police after the second hospitalization, however, it describes behavior that occurred before the first hospitalization. Had the social worker properly interviewed the child's mother, Kayla, this information may have been made available.

<u>Information available from Charlotte Williams (maternal grandmother)</u>

- "Michael was not working...This was a point of stress for Kayla...I had reservations about Michael being my daughter's mate...Kayla could do better than him...He played video games and was not working...he was not a good provider...Kayla would say 'don't start' [nagging me about Michael]...This became a stressor for Michael also."[C WILLIAMS 114:7-13, 114:18-20, 114:23-24, 115:7-12, 116:1-8]

  Comments: Additional information that was available with a proper interview by the social worker, supportive of a high-risk profile for possible abuse.

- "I knew this was coming" [C WILLIAMS 154:2-8]

  Comments: This statement was made to the detective, Amanda Carter, after the child was re-injured in January, 2010. Although Charlotte Williams attributes this to being "angry" and "scared", it does reveal some of her underlying feelings that, if properly assessed in the hands of a skilled social worker, could have helped to further support the nature of the high risk profile.

- As early as November, 2009 (one month prior to the first hospitalization in December, 2009) MGM had suspicions about Michael being abusive toward [redacted]. She noted a bruise on his forehead and a scratch and only Michael and his brother Brian had the baby all day; Michael is rough with the baby; Michael needs to be reminded to pick up the baby's head; when confronted by MGM about Michael's inappropriate ways of managing [redacted], Kayla's reaction was "oh, don't start that again!"; Michael never talked to the baby at home; Michael plays video games 24/7 with his brother; "Kayla is protecting Michael"; Kayla kicked Michael out of house after the first incident and he lost his job; the parents usually just stick [redacted] in the swing all day; MGM never saw Michael rock [redacted] in the rocking chair. [DSS 00171, DEF PROD 00199, 00235, DSSYS0049]

  Comments: Had this information been elicited, all of these issues reflect serious concerns regarding the safety of the child with the parents, especially the father.

- [Regarding the observed bruises by MGM in November, 2009]: "She took a picture of the bruise." Michael and Brian had the baby that day. This was the week prior to the first hospitalization. "[redacted] was crying a lot". The child was taken to the doctor at Sunshine Pediatric Center and was told he had a throat infection.

  Comments: If maternal grandmother (MGM) was adequately interviewed, this picture would have raised the need for safety precautions given a prior history of possible abuse. The defense will say MGM should have reported this in December—and she should have. She may have not been sure, not certain this was the case, did not want to believe it, not remembered in the stress of the moment, etc. But she should have been asked and adequately interviewed in order to elicit this information. This is the responsibility of the social worker to get the big picture through an independent assessment.

- Lynn Meyers, LCSW, the hospital "Child Maltreatment Coordinator" (at the time of the 2nd hospitalization): "expressed concerns (to the DSS caseworker) that MGM may have known about [redacted] and being shaken. The MGM told hospital staff that she has seen bruises on the child." [DSS 00271]

  Comments: Although this is at the time of the second hospitalization, the MGM also had concerns in November, 2009 about bruises/scratches. This information should have been elicited in December, 2009.

- [Kayla reported to DSS that] "MGM never liked Michael because of the way he looked and he was a lazy kid and felt she could do better. MGM always disagreed with Michael" [DSS 00248]

  Comments: Issues in how the grandmother perceived Michael were relevant in understanding the risk profile.

- MGM noted to have a criminal history (misdemeanors) including unlawful alcohol concentration, no proof of insurance of vehicle, simple assault. [DSS 00219]

  Comments: If MGM had been appropriately interviewed and her background checked, such information would have been noted raising the risk profile while also ruling out the child's grandmother for an alternative placement at discharge.

- "I think that [Michael] cared for [redacted] when he had to." [C WILLIAMS, 105:22-25]

  Comments: Suggests a need to be told to take care of the child.

<u>Information available from Larry Williams (maternal step-grandfather)</u>

- "I know [redacted] was crying a lot...It even got to the point that I told Charlotte that [Michael] needs to be a responsible dad and take on responsibility himself...Looking back there probably were some signs but we were just too involved in it...we just missed those signs." [L WILLIAMS 34:22-25, 65:4-6. 69:12-15]

  Comments: Further support for one of the common triggers of abuse, particularly in the context of the other risk factors noted as well as the father's lack of responsibility. The vague sense that "there probably were some signs" might have been more fully elicited had the social worker probed and explored these concerns properly.

<u>Misunderstood observations and/or assumptions of low risk:</u>

- [The general findings of no conclusive medical evidence of non-accidental trauma (NAT)].

  Comments: The absence of evidence of NAT does not de facto mean it was therefore accidental trauma (AT). It simply means we do not know and the presumption of risk must still be maintained and offset in the discharge plan.

- [Findings of a negative skeletal survey] [COURTLAND 45:15-24]

  Comments: *The absence of fractures does not equate with the absence of abuse. The abuse may have been of insufficient intensity to cause fractures per se. Thus, the risk is not diminished.*

- Parents observed to be "involved, appropriate, good eye contact, loving...while in hospital." [COURTLAND 36:3-8]

  Comments: This was under the constant monitored supervision and structure of a hospital sitter and not indicative of how they might act in the unmonitored, unstructured environment at home, thus not supportive of a determination of lower risk.

- "They think that maybe nobody was supervising him and he bumped his head or they were holding him and walking around the door and banged his head or something." [HINNANT 83:25, 84:1-3]

  Comments: The risk assessment should be based on known facts not conjecture. In the absence of known facts, if an assumption must be made, the practitioner should err on the side of caution in making assumptions (i.e., that it possibly is NAT). Instead, this assumes that the injury was accidental.

- [The hospital staff] "...thought that DSS was there to release the sitter so they could...go home, and there was no concerns for the child, that it was accidental." [AUDIO TRANSCRIPTS, LOLA DSS PART 1, 12/17/09]

  Comments: Again, the notion that the child's injuries were likely accidental was communicated to DSS by the hospital social worker.

- "Laura [Newmark, the hospital social worker] stated at this point there are no obvious signs of abuse or neglect, but they were going to follow-up with the family in two weeks. [AUDIO TRANSCRIPTS, LOLA DSS PART 1, 12/17/09]

  Comments: There are not always obvious signs of abuse or neglect. This is why the psychosocial assessment of risk factors that examine the potential are so critical in establishing the appropriate level of safety precautions to take.

- "...by asking for a child maltreatment evaluation...getting DSS and law enforcement involved...That's how you err on the side of caution." [COURTLAND, 41:7-13]

Comments: These are appropriate steps to take but not adequate or cautious enough to address the unknown variables and lag period that would follow while DSS completed its investigation given the psychosocial risk profile.

- [To ensure a baby is safe] "You put in place a safety plan and you report them to the Department of Social Services and you get law enforcement...to investigate..." [COURTLAND 48:7-12]

  Comments: This is correct in theory but was not implemented in reality. The "safety plan" was only nominal in nature. It was inadequate to effectively address the risk. In fact, law enforcement was not involved at all.

- [DSS has 45 days or more to complete an investigation.]

  Comments: Therefore, in the interim, in an unsupervised home environment, the risk was still present and needed to be offset.

- [The issue of suspected child abuse is based on] "not probability, possibility..." [COURTLAND 63:5-9]

  Comments: The fact that there was no certainty in ruling in/out NAT was not a reason to exercise less caution in the discharge plan. The probability that it was abuse was not necessary to warrant caution, only the possibility.

- "The [medical] information was not able to be obtained, what we had available at the time [to determine if the injury was NAT]" [COURTLAND 64:5-6]

  Comments: This is why the psychosocial data from the social worker becomes that much more important. In the absence of conclusive medical findings of abuse, the psychosocial data is key in determining the possible factors that give context to the medical findings with regard to potential risk of harm.

- The child's developmental milestone markers indicated that he "was not able to" roll, crawl, or walk. [COURTLAND 64:19-23]

  Comments: *In the absence of parental explanations for the injury, this lends even more credence to the possibility of NAT.*

- "OK to discharge under supervision—will need to see in follow-up in 2 weeks." [COURTLAND, Exhibit 30]

  Comments: The question is who needed the supervision, the child or the parents. Clearly, the available data indicated a need for supervision for the parents as much as for the child.

- "Please return in 2 weeks for repeat skeletal survey" [COURTLAND Exhibit 32]

  Comments: The fact that a repeat skeletal survey was requested clearly indicates the continued suspicion that existed for the possibility of re-injury of the child. Despite this as being part of the discharge plan, the child was still returned to the unsupervised care of the parents who were still under suspicion of possible abuse.

- [Is the absence of a retinal hemorrhage, does that rule out that there is non-accidental trauma?] "No, it wouldn't...there would be, obviously, different ways to traumatize a child. [COOK 22:4]

  Comments: Despite this negative medical finding, the psychosocial risk was still resent and misunderstood by the social worker.

Failure to thoroughly interview, probe, and explore the parents and other relevant collateral sources

Comments: Refer to above section for the information that may have been obtained had the family members noted been interviewed properly by the social worker(s). Such interviews should be conducted separately. The record reflects that the interviews that were conducted were done with others family members in the room.

Additional collateral sources that were available sources of information for the social worker to contact if/as necessary include: Daniel Lythgoe (paternal grandfather), Jennifer Lyhgoe (paternal grandmother), Aaron Lythgoe (father's step-brother, age 12), and the "Thursday babysitter" (This person was never identified or interviewed)

Failure to request pertinent background records

Comments: There is no documentation that any medical, police, prior treatment, or other records were requested by the social workers. Such records are invaluable in conducting a comprehensive psychosocial assessment.

Failure to utilize standardized child abuse screening tools, inventories, and testing

Comments: The use of risk assessment instruments, inventories, and/or screening tools is generally considered to be useful in assessments for potential child abuse (e.g., Child Abuse Potential Inventory, Child Maltreatment Interview Schedule, The Parent Stress Index, etc.) A request to get a psychologist to administer these or any other tools to assess the risk potential for harm of the child should have been made. Such instruments are not used to determine who committed the abuse but instead to measure parental characteristics and family conditions that are believed to be predictors or precursors of potential child maltreatment or other harm to the child in order to determine the level of safety needed before the child is returned home.

COMMUNICATION

Failure of to fully comprehend the professional social work role and responsibilities within the context of the hospital's multi-disciplinary team and the inter-collaborative relationship with DSS

- "My responsibility as the medical social worker is to communicate information to DSS from the team and back to the medical team from DSS...["...all you are is just a messenger back and forth between the two of them?] "...No, I can give my opinion to the doctors...and say that if there's anything in particular"...["Well, in this particular case, what insight did you give to the doctors?"] "I don't recall, off the top of my head..." [NEMWMARK 33:9; 55:10; 55:15]

  Comments: Communicating with the team and outside agencies is only one facet of the social worker's role and responsibilities. The information that is communicated must include the social worker's psychosocial assessment, which is an integral part of the hospital team's information that must be gathered. The social work role is clinical, not just clerical. The professional social worker's perspective and contribution to the clinical picture is central to the hospital team's workup. Not only can the social worker give an opinion, this is what the social worker must do in ensuring that the hospital team has a complete understanding of the psychosocial dimensions of the patient's concerns and needs. In this case, the social worker did not contribute the social work perspective within the standard of care.

- "Part of the safety net and working on discharge, as far as the hospital social work piece, is to get DSS involved, because they can be involved in the home community, where we can't." [NEMWMARK 31:20]

  Comments: Yes, part of the discharge "safety net" is to make a referral to DSS, but the other parts are to provide accurate information to the hospital team and other agencies based on a comprehensive psychosocial assessment, then offset that risk before the child is returned to the home/community, precisely because you don't know what might happen while DSS conducts its investigation.

- "I think that the medical team has a responsibility to do a workup on a child that comes in with an unexplained injury and part of that is calling DSS, working with them, making sure they have all the right information, doing everything we can to do a complete workup, as a way to help protect him [the child]." [NEMWMARK 47:6]

  Comments: Yes, this is a more accurate understanding of the hospital's responsibility to ensure a safe discharge back to a safe environment, but the social worker did not make sure DSS "had all the right information" or "do everything we can to do a complete workup". To do so requires that the social worker contribution begins with a comprehensive psychosocial assessment.

- "I don't have any say as to where [the child] goes upon discharge, as a hospital employee...; I'm a liaison between the medical team and DSS...I share information on the clinical status and what's going on with the patient with DSS, who has the ultimate discharge plan put in place...I give them information. I don't control the final decision...; Disposition and discharge would be at the DSS discretion...[the state's responsibility?]...yeah, it's DSS...; In my experience...DSS tells us...when there's an open investigation, where the child is going to be discharged to...; Disposition has been determined by medical social worker and DSS—the way I could read that, back to me being a liaison, that I'm making sure that the team knows that DSS is involved in what they recommend." [NEWMARK 10:15, 10:25-11:1, 11:16, 11:24, 115:11, 115:17, 116:22]

  Comments: The social worker clearly misunderstands her professional role in the multi-disciplinary team. She describes her role as primarily passing information onto DSS about the clinical status of the patient, yet diminishes her own responsibility in contributing to that information in terms of her own assessment of the patient's status. In effect, she describes her role as more clerical than clinical. In fact, as the social worker, the primary professional responsibilities include initial screening

and evaluation of patient and families, conducting comprehensive psychosocial assessments, counseling, crisis intervention, information and referral, educating hospital staff on patient psychosocial issues, promoting communication and collaboration among health care team members, and coordinating patient discharge and continuity of care planning, among other duties. The social worker is responsible for putting the medical data into a psychosocial context. While the physicians attempt to determine the etiology of the child's injuries based on the medical evidence, the medical social worker attempts to determine the etiology and intentionality of the injuries based on the psychosocial evidence. This is a key clinical and decisional responsibility, one which in the absence of conclusive medical data, becomes that much more critical.

- "When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS....MSW involved...Check with medical social worker about discharge...Extensive conversation with Dr. Morgan-Glenn [and] medical social worker regarding case...DSS to follow family with home visits, supervision...[Plan] cleared by medical social worker...[Per] DSS/social worker, OK to discharge with mom and dad. Will discharge home...Discharge home with parents with medical social work approval...Pending social work OK, patient OK to discharge" [COURTLAND Exhibits 2, 22, 23, 34, 35; COURTLAND 105-108]

  Comments: The attending pediatric physician and other medical professionals clearly rely on the input of the medical social worker with regard to the discharge planning process. Although there is a liaison component to the social work position, this is in regard to the responsibility to communicate relevant information with the team and outside agencies only. In arriving at a discharge disposition, the content of the social work psychosocial assessment is in large measure the key information that must be communicated to DSS in addition to the medical data as reported to the social worker by the physicians and other ancillary staff. The social work role is clearly much more than that of a liaison passing along information to DSS. The medical professionals within the hospital's multidisciplinary team distinctly recognize the decisional component of the social work role. In cases of suspected child abuse, the decision to discharge is the joint responsibility of both the social worker AND DSS, not either one independent of the other.

Failure to collaborate, consult, and follow-up appropriately with the hospital multi-disciplinary team, Department of Social Services (DSS), and/or others to effectively ascertain and communicate the nature of the high-risk for child abuse

Comments: There is no documentation anywhere in the record that the social worker communicated to any member of the hospital multi-disciplinary team, to DSS, or to law enforcement, any specific concerns regarding the family risk profile that would alert anyone among the inter-collaborative agencies involved, to the need for exercising caution in the discharge plan other than making a referral to DSS. This reflects the social workers lack of comprehension of the risk factors themselves. The referral to DSS was legally mandated based on the suspicion of abuse and does not reflect any degree of appropriate caution in protecting the child by recommending to anyone a more structured discharge plan and/or safety plan. In failing to appropriately assess, comprehend, and then communicate the inherent risk profile to the hospital multi-disciplinary team and DSS, the social worker set into motion a causal chain of misinformation that, passed from agency to agency, distorted and minimized the true nature of the high inherent risk for abuse and the need for more structured precautions.

- "I think the hospital fulfilled its duty in making the report to DSS and providing them with up-to-date- information." [NEWMARK 35:20]

  Comments: The hospital's, and more specifically the social workers', duty was to conduct a competent psychosocial assessment, communicate accurately the potential risk of harm to the child, make a referral to DSS, then implement a safe discharge plan while DSS conducted its investigation. The ability to provide "up-to-date information" from the social work perspective assumes that a competent psychosocial risk assessment was conducted and communicated in addition to the medical findings. This, however, was not the case.

- [Regarding the role the hospital plays in DSS's investigation] "...we would certainly interview them and take into consideration any concerns that they have." [Do you look to them to help make your case decisions?] "Absolutely." [HINNANT 26:8]

  Comments: The DSS supervisor highlights the fact that they depend on the input of the hospital staff to make their dispositions. The social work input is critical with regard to the psychosocial aspects of the case.

- "...If there had been something else that was of concern [as communicated by the hospital social worker], we may still have indicated our case...there were concerns that the parents were young and that they were immature and, maybe...concerns of lack of supervision." [HINNANT 64:5-12]

  Comments: The concerns communicated to DSS indicate that the hospital's understanding of the risk to harm was grossly diminished, despite the numerous risk factors present and documented. The focus of "concerns" was around the parents' immaturity and lack of supervision of the child. This indicates that the hospital's understanding of the injuries (as communicated by the social worker) were skewed toward an interpretation and assumption of accidental trauma, when the risk of non-accidental trauma had not yet been ruled out. This tainted assessment of the facts significantly compromised an accurate communication of the facts to DSS.

- [We let the child go home because] "...the hospital wouldn't make a statement whether or not it was accidental or non-accidental...we had nothing...They said their concern was a lack of supervision...that someone wasn't watching the baby...somehow his head could've been bumped...they wont go on record saying it was either accidental trauma or non-accidental trauma. They weren't going to tell me...The hospital, they have implications in their case record that grandmother knew this was happening and di nothing...she had an idea...saw marks...I wish she had called us...They [the hospital] weren't giving us any indications that they had any real concerns, all those things that would indicate that the baby had been shaken, they didn't have any...See they [the hospital] should've been calling and making a report to us...had they any concerns...see, we could have looked at it a lot differently...that they [the parents] were acting suspicious and Kayla had called one day and made a remark that she was going to lose it, to come get the baby...so they didn't tell us any of this until afterwards...They're not giving us a whole lot. You know they won't make statements...And what happened is the social worker made the report on this and the doctor did not advise the social worker to make the report. They made that real clear to me when I called and spoke with them at the hospital...In this case they're not [giving us enough reason to remove the child] They don't have any suspicions." [AUDIO TRANSCRIPTS, CHRISTA DSS, 01/19/10]; [HINNANT 83:10-22]

  Comments: The DSS supervisor clearly indicates the diminished sense of risk that was communicated by the hospital social worker. The social worker essentially reported only the medical findings to DSS, indicating that they could not rule out non-accidental trauma. None of the contextual

psychosocial risk factors were communicated. As a result, beyond simply reporting a lack of conclusive finding of abuse, the sense of risk was further diminished in conveying that the injury was more likely than not, accidental. Beyond not giving DSS a specific finding of abuse, the key is here is that the sense of risk was specifically minimized. This miscommunication of the potential risk was based on both the inadequate psychosocial assessment and the lack of comprehension of the significance of the available information by the hospital social worker.

- ["...(W)hat input does the hospital have into that (discharge) decision?"] "...any concerns that they have had for us to address." [HILL 42:20]

  Comments: DSS clearly relies on the hospital to communicate "any concerns" they may have with regard to their assessment of the child's needs.

- "Along with all that and what y'all had told me...I felt comfortable with it [not sending out a police investigator]. Maybe I shouldn't have...I didn't ever see that stuff that the grandfather or whoever it was said...they had seen all these mysterious bruises, and they even went so far as to photograph a bruise on the child at some point. See we weren't even made aware of any of that...If I can get all the information then it gives me a whole lot clearer [picture]...like what I'm reading here [about the subdural hematomas]...I'm going head-hunting!...But that one [the subdural hematoma] that went behind the...skull...you know that's not something they usually get by just falling, Lola....There's no consistency [in this case as to the parent's explanation of the injuries]...We definitely need to find out what the uncle's deal is, who he is, you know, all that good stuff...We're supposed to work as a team, we're not supposed to be pulling away from each other." [AUDIO TRANSCRIPTS, CHRISTA DSS, 01/19/10; LOLA DSS PART 1 & 2, 12/17/09]

  Comments: After the child was re-injured in January,2010, law enforcement (Lt. Miller) describes clearly how he was influenced by the diminished sense of risk and lack of information communicated to DSS by the hospital and then by DSS to him to the extent that the York County Sheriff's Office never initiated an investigation into the matter in December, 2009. Additionally, he articulates the suspicions he would have had regarding the case and how he would have explored these more fully than was already the case by both DSS and the hospital.

- "I think I would continue to work with community resources and make sure that there was going to be appropriate follow-up, if we were concerned that the follow-up wasn't going to happen. [NEWMARK 115:4]

Comments: One of the duties of the hospital social worker is to follow-up regarding the status of the collaborative referrals that are made in the community. The record does not indicate that any such follow-up was made by the social worker with DSS, the family, or any other agency. There was a follow-up skeletal survey scheduled outside of the hospital, but no social work follow-up is documented that considered the results of that second survey.

- "Yeah. It's like this one really fell through the cracks because nobody—PMC (Piedmont Medical Center) didn't call law enforcement on that one, and Levine's never called law enforcement. It's like, 'Holy crap.'" [AUDIO TRANSCRIPT, CHRISTA DSS PART 1 & 2, 12/17/09]

  Comments: The option to refer a case to law enforcement is not the exclusive responsibility of DSS alone. Anyone can make such a referral. Given the nature of the risk profile, there was nothing to preclude the hospital social workers from contacting law enforcement in the interest of erring on the side of caution. Such a referral was never made.

INTERVENTION

Failure to develop an appropriate differential discharge plan that adequately utilized the numerous alternatives, options, and community-based resources available to ensure the child's safety

Comments: Because the social worker did not comprehend the inherent risk in a discharge to the home setting under the parents' supervision while DSS conducted its investigation over a period of weeks, the available alternatives for implementing a safe discharge plan were not considered. Some possible considerations include:

Temporary foster care
Court order for ex parte removal of child
Live-in care
Initiate/coordinate law enforcement investigation
Appoint a Guardian Ad Litem
Delay discharge; keep in hospital until safety plan is established
Relative placement (assuming they have been evaluated and cleared)
Clear all visitation with DSS
Mother and father supervised at all times
Obtain a restraining order

Examples of other appropriate discharge plans that could have been considered (based on the Jan, 2010, second hospital encounter):

- [On 01/11/10, as the DSS investigation began at the time of the second hospitalization, the following safety plan was written]: "Safety Plan: ...Kayla and Michael will have no unsupervised contact with [redacted] will not go home with Kayla and Michael. Levine's Children's Hospital will contact York County Department of Social Services when minor child to be released/discharged. Both parents will comply with safety plan—failure will result in court intervention. Case manager Hill will follow up with ALL parties and request records, etc...A copy of the safety plan was placed in Owen's file." [DSS00278]

  Comments: This is exactly what should have been done at the time of the first hospitalization in December, 2009. If the risk was comprehended appropriately based on a competent and coordinated assessment by the social worker, this is all that had to be done at the time of discharge, to protect Owen while the appropriate investigation was further conducted by DSS and law enforcement.

- "Kayla Lythgoe will ensure that all immediate family including herself, grandparents, and step-grandparents, uncles, aunts, and cousins are to have supervised contact with [redacted] Kayla Lythgoe is responsible for ensuring compliance with the safety plan...A nursing assistant (sitter) was responsible to sit inside the room with the child and mother at all times...DSS will monitor safety plan through follow-up with Levine Children's Hospital. [The hospital] and or their designee is responsible for ensuring compliance with this safety plan." [DSS 00242-00243]

  Comments: The known collateral sources should have been interviewed and such a plan put in place at the first hospitalization. Clearly, DSS looks to the hospital to assist in managing the discharge plan.

- January, 2010, second encounter: "[redacted]s DC is currently on hold secondary to DSS prohibiting him from going home with his mother with his grandmother present. His mother is currently working on clarifying what she needs to do to take [redacted] home with DSS and working on finding alternate housing so she does not have to stay with her mother." [DSS 0017]

- "Visitation plan continues to involve supervised visits only for [redacted]s maternal grandparents." [DSS0017]

- "Grandparents must legally supervise mother (and father) at all times." [DSS0045]

- "Safety Plan: Kayla and Michael will have no unsupervised contact with [redacted] will not go home with Kayla and Michael." [DSS00147]

DOCUMENTATION

Failure to document effectively the nature of the assessment, communication, and interventions related to the high-risk for child abuse

- [The Suspected Chile Abuse and Neglect form (SCAN) "wasn't completely filled...out because...that's a form that's used on admission. So all the information that is required to be put in that form had already been gathered before." [COURTLAND 55:7-13]

  Comments: *But the information to be gathered by the nurse [Lynn Meyers, RN] was not documented anywhere while the information that was documented by the hospital social worker was inadequate as well. The fact that the injury was not determined until after admission does not preclude each practitioner from conducting their own independent assessment before discharge. Each staff member has a responsibility to complete their own independent assessment during the hospitalization and to not "rubberstamp" the assessments of others.*

IV. Conclusion

Although the defense contends that: "[t]he decision regarding the discharge of a child into the custody of his parents or to some other person or entity is a decision that must be made by the Department of Social Services (DSS), by law enforcement, or by the courts, and is not a decision which can be made by a hospital or physician [MOTION FOR SUMMARY JUDGMENT]", this is not the case.

As outlined in the hospital's (CMC) Child Abuse and Neglect Algorithm [NEWMARK Exhibit 2], in cases of suspected child abuse or neglect, discharge decisions are the joint responsibility of the hospital and DSS who work together to determine the appropriate disposition for the child. Specifically, the algorithm states: "When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS [NEWMARK Exhibit 2]."

DSS and law enforcement each depend upon the hospital's assessment of risk, which is based on a combination of both medical and psychosocial data. Within the context of the multi-disciplinary team model, the medical data is the responsibility of the hospital physicians, nurses, child maltreatment specialist, and other ancillary staff while the psychosocial data is the responsibility of the hospital social workers. The hospital discharge plan is the culmination of this two-pronged assessment of medical and psychosocial risk.

In December, 2009, although purportedly designed to offset the risk of the possibility of non-accidental trauma, both the hospital's discharge plan and DSS's safety plan clearly were based on the assumption that the child's injuries were more likely than not, accidental. This is evidenced by the fact that, while the parents were still under suspicion of having possibly abused the child, the child was placed back into their very care with instructions that they were to "...supervise [redacted] at all times and follow-up with all medical appointments...until [DSS] investigation ends [DEF PROD00166]. In essence, by allowing the child to return home in the control of the parents without the benefit of closely supervised, structured monitoring, the hospital (in conjunction with DSS) placed the child under the control of the two primary suspected potential perpetrators. This is analogous to appointing the fox to guard the henhouse.

In effect, the hospital's discharge plan and DSS's safety plan instructed the parents to closely monitor the *child's* behavior, rather than setting up a plan in which the *parents'* behavior could be closely monitored and supervised, given the fact that they were still under continued suspicion for abuse. Given the inability of the hospital to rule out non-accidental trauma and the concomitant high-risk profile reflected in the psychosocial data available at the time, to instruct the parents to monitor the child without putting in place structured measures that would closely monitor and supervise the parents while DSS could complete it's

investigation, was medically reckless. In such potentially high-risk scenarios, the standard of care is to err on the side of caution, especially in the face of numerous identified risk factors. In discharging the child under the supervision of his parents, by default, both the hospital and DSS instead erred on the side of assumption, that is, assuming the injuries were more likely than not, accidental.

In this manner, within the context of the interagency collaboration between the hospital, DSS, and law enforcement, in December, 2009, a causal chain of dangerously inaccurate information was communicated, beginning with the hospital social worker's deficient assessment of the psychosocial risk factors and her lack of comprehension of the resulting inherently high-risk of potential harm to the child. Acting in her liaison role with DSS, this lack of comprehension of the inherent risk, in combination with the non-conclusive medical data, was communicated to DSS, distorting and diminishing for DSS their overall understanding of the true nature of the inherent risk. This mitigated perception of risk then became the basis for the conjoint decision by both the hospital and DSS to discharge the child into the parents' care.

When DSS in turn communicated their distorted and diminished perception of the risk profile to law enforcement, it was once again misevaluated by law enforcement to be low therefore leading law enforcement to decide not to become involved in the case at all. But for the hospital social workers deficient assessment of the psychosocial risk factors and lack of comprehension of the resulting inherently high-risk of potential harm to the child, in addition to miscommunication referenced above, it is more likely than not this child would have been placed into custody with some other person than the custodial parents and the tragic situation in January 2010 would have been avoided.

Beginning with the hospital social workers whose primary role is to facilitate the safe transition from one level of care to another, they have a duty to conduct a competent psychosocial assessment, communicate accurately the results of that assessment to the relevant parties, refer the case to DSS, then implement a safe discharge plan that accurately takes the results of the assessment into account in order to prevent the risk of harm to the child. Although making a referral to DSS to investigate the case was a necessary step in discharging this duty, it was not sufficient. Providing DSS with an accurate appraisal of the potential risk of harm based on a competent psychosocial assessment and arranging for the child's safety while DSS completed its investigation was necessary. By breeching this duty, a causal chain of misunderstood and miscommunicated risk of potential harm ultimately led each organization involved in the continuum of care to not take the appropriate steps to put into place adequate safety measures necessary to protect the child, thereby resulting in the child's re-injury in January, 2010.

GEORGE W. SAVARESE, PhD, LCSW

Sworn to and signed before me
this 6 day of April, 2013

Notary Public

"OFFICIAL SEAL"
Marina L. Stevens
Notary Public, State of Illinois
My Commission Expires 10/26/2016

My Commission expires: 10/26/2016

Index for Savarese Exhibits

1. George W. Savarese, Ph.D., LCSW Curriculum Vitae
2. NASW Code of Ethics 2008
3. NASW Clinical Social Work in Social Work Practice 2005
4. NASW Social Work Practice in Health Care Settings 2005
5. NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
6. [NEWMARK EXHIBIT 10] Juveniles Suspected of Being Abused or Neglected PR 110.03
7. [COURTLAND EXHIBIT 14]Evaluation of Suspected Child Physical Abuse 2007
8. [NEWMARK EXHIBIT 1]
9. York County [DSS 00143]
10. York County [DSS 00176]
11. York County [DSS 00179]
12. [SHER 0027-0028]
13. [DEF PROD 00219-0227] or [DSS-YS 0070-0078]
14. York County [DSS 00247]
15. York County [DSS 00236]
16. York County [DSS 00237] AND [DEF PROD 002916-17] or [SCDSS 0242-0243]
17. York County [DSS 00251]
18. York County [DSS 00248] actually [DSS 00247]
19. [SHER 000019-23]
20. York County [DSS 00171]
21. DEF PROD 00199] or [DSS-YS 0049]
22. York County [DSS 00271]
23. York County [DSS 00219] actually [DSS 00220]

24. [AUDIO TRANSCRIPTS, LOLA DSS PART 1 12/17/09] & PART 2 included
25. [COURTLAND, EXHIBIT 30] or CMC (12.05.09) 0039
26. [COURTLAND, EXHIBIT 32] or CMC (12.05.09) 003-4
27. [COOK 22:4]
28. [COURTLAND, EXHIBIT 2] actually [NEWMARK EXHIBIT 2]
29. [COURTLAND, EXHIBIT 22]
30. [COURTLAND, EXHIBIT 23]
31. [COURTLAND, EXHIBIT 34]
32. [COURTLAND, EXHIBIT 35]
33. [AUDIO TRANSCRIPTS CHRISTA DSS, 01/19/10]
34. York County [DSS 00278]
35. York County [DSS 00242-243]
36. York County [DSS 0017]
37. York County [DSS 0045]
38. York County [DSS 0147] Actually DEF PROD 00194 or DSS YS 0045
39. Excerpts from the Deposition of Laura NEWMARK
40. Excerpts from the Deposition of Cheryl COURTLANDT
41. Excerpts from the Deposition of Dirvondra HILL
42. Excerpts from the Deposition of Krista HINNANT
43. Excerpts from the Deposition of Rev. Larry WILLIAMS
44. Excerpts from the Deposition of Charlotte WILLIAMS
45. Excerpts from the Deposition of Kayla LYTHGROE

EXHIBIT

"1"

George William Savarese, Ph.D., LCSW
637 East Golf Road, Suite 201
Arlington Heights, Illinois 60005
847-791-1950 phone
817-549-6460 efax

EDUCATION

PH.D.
University of Chicago, School of Social Service Administration, Chicago, Illinois
Concentration: Clinical Social Work/Social Administration/Social Policy Analysis
Dissertation: "Practitioner activity in a family-based approach to treatment of the elderly." A content analysis of an inchoate behavioral treatment model designed to train elderly clients and their families how to modify a wide range of problematic behaviors was conducted in an attempt to offset the need for institutional placement.
June, 1989

M.S.W.
New York University, School of Social Work, New York, New York
Concentration: Clinical Social Work/Social Administration
June, 1980

B.A.
City College of New York, School of Liberal Arts, New York, New York
Concentration: Psychology/Sociology
February, 1978

ADMINISTRATIVE EXPERIENCE

Curaeta Care Systems, Park Ridge & Arlington Heights, Illinois
January, 1995 to present

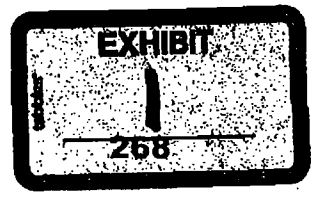
Executive Clinical Director. Founded and direct a private psychosocial services consultation organization which provides psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets; Direct the strategic planning, organizational and program development, research, operations, and supervision of network providers; Provide delivery of direct clinical services through four key programs:

CURAETA*OfCounsel.* Provide forensic consultation services nationally in criminal, civil, and military court proceedings. Services provided include biopsychosocial developmental evaluations, case management services, resource and referral services, research and expert testimony in federal, state, and military jurisdictions. Cases handled include death penalty, death penalty clemency, military courts martial, military separation/discharge, medical malpractice, social work malpractice, immigration, misdemeanor criminal, institutional neglect/abuse, attorney registration and disciplinary hearings, wrongful death, worker's compensation, and personal injury cases.

CURAETA*OnCall.* Provide clinical and medical social work services to home health care providers and hospice agencies as well as behavioral health services for developmentally disabled adults to DHS CILA providers. Services provided include comprehensive psychosocial assessments, behavioral intervention planning, behavioral therapy and counseling, psychosocial risk screening; psychosocial treatment planning and review; case management; information and referral; community resource linkage; crisis intervention; patient and family advocacy; interdisciplinary consultation; discharge planning; post- discharge follow-up; short-term, solution focused counseling; family counseling; behavior modification; case management services for dementia and Alzheimer's patients and their families; and patient and family education.

CURAETA*AtHome.* Provide home-based, neurobehavioral and psychosocial rehabilitation services to patients and their families addressing community-reentry issues associated with traumatic brain injuries, spinal cord injuries, and various other disabling health conditions.

CURAETA*InService.* Provide in-service training and clinical supervision services to various medical facilities, schools, and other health-based and social service organizations.



Texas Research Institute of Mental Sciences, Houston, Texas
July, 1980 to September, 1982

Assistant Administrator, Adult Outpatient Services. Planned, recommended, and coordinated the development of techniques, standards, policies and procedures for the improvement of departmental programs; Reviewed appropriate staffing levels; Assisted in forecasting and budget preparation and control; Consulted with and advised departmental head regarding operational problems; Prepared written reports for staff meetings, governing, and regulating bodies; Represented department in absence of departmental head; Provided consultation to other institute staff in understanding and utilizing departmental services; Worked with and made presentations to civic and professional groups to coordinate, improve, and stimulate appropriate utilization of services; Participated in training projects to promote staff development; Compiled statistical data regarding operation of the department; Designed data collection instruments for departmental management information system; Produced training manuals; Produced staff procedures manual

Coordinator, Central Intake/Information and Referral Services. Coordinated overall intake and referral procedures and scheduling of patients; Direct supervision and evaluation of assigned staff; Recruited and hired staff; Reported human resources logistical needs, requirements and accomplishments; Conducted staff meetings; Reviewed statistical data regarding service operation; Screened new admissions; Interviewed walk-ins; Provided crisis-intervention; Interviewed and screened subjects for psycho-pharmocological research; Developed and maintained community resource database; Reduced 3 month waiting list to 3 weeks

ACADEMIC EXPERIENCE

University of Chicago, School of Social Service Administration, Chicago, Illinois
January, 2002 to present

Lecturer. Teach the graduate-level core curriculum course "Social Interventions: Policies and Programs"; Participate in departmental meetings; Advise and counsel students regarding academic issues

Columbia College Chicago, Chicago, Illinois
January, 2010 to present

Adjunct Professor. Teach the graduate-level core curriculum course "Psychopathology"; Participate in departmental meetings; Advise and counsel students regarding academic issues

Governors State University, College of Health Professions, University Park, Illinois
August, 1989 to December, 1998

Adjunct Professor. Taught the undergraduate-level core curriculum course in Social Welfare Policy; Participated in departmental meetings; Advised and counseled students regarding academic issues; Assisted departmental head in Council on Social Work Education accreditation process

University of Chicago, School of Social Service Administration, Chicago, Illinois
September, 1992 to present

Clinical Field Instructor. Provide clinical field instruction to graduate clinical social work interns in clinical assessment, diagnosis, and research methodologies; Coordinate student involvement in on-going clinical research study evaluating biopsychosocial developmental risk/protective factors associated with violent criminal behavior; Participate in student training workshops

Loyola University, Applied Psychology Program, Evanston, Illinois
September, 1992 to June, 1996

Clinical Field Instructor. Provided clinical field instruction to undergraduate psychology interns in clinical assessment, diagnosis, and research methodologies; Coordinated student involvement in on-going clinical research study evaluating biopsychosocial developmental risk/protective factors associated with violent criminal behavior

University of Illinois, Jane Addams School of Social Work, Chicago, Illinois
September, 2001 to June, 2002

Clinical Field Instructor. Provided clinical field instruction to graduate social work interns in clinical assessment, diagnosis, and research methodologies; Coordinated student involvement in the delivery of medical social work services

Governors State University, College of Health Professions, University Park, Illinois
September, 1993 to June, 1994

Clinical Field Instructor. Provided clinical field instruction to undergraduate clinical social work interns in geriatric assessment, case management, community resource linkage and discharge planning methodologies

TRAINING EXPERIENCE

Private Clinical Social Work Consultation Practice, Park Ridge & Arlington Heights, Illinois
June, 1989 to present

Consultant/Trainer/Workshop Facilitator. Provide a wide range of in-service training workshops and presentations to payers, managed care companies, case management organizations, hospitals, home health agencies, social service agencies, and other human service organizations to include various clinical, medical and forensic social work training presentations, discharge planning, teamwork workshop consultations, and behavioral healthcare presentations

Texas Research Institute of Mental Sciences, Houston, Texas
July, 1980 to September, 1982

Faculty Training Coordinator, Department of Continuing Education. Developed and coordinated various statewide training workshops for Texas Department pf Mental health and Retardation

CLINICAL EXPERIENCE

Curaeta Care Systems, Park Ridge & Arlington Heights, Illinois
January, 1995 to present

Clinical, Medical, and Forensic Social Work Consultation. Provide direct clinical, medical, and forensic social work consultation services through the CURAETA*OfCounsel*, *OnCall*, *AtHome*, and *InService* programs detailed above under "Administrative Experience".

Gentiva Health Services, Home Health Care Division, Hickory Hills, Illinois
January, 1992 to September, 2006

Medical Social Worker. Instructed, treated, observed, and evaluated clients exhibiting significant social and emotional problems affecting their health status; Participated in the development and periodic re-evaluation of the Physician's Plan of Treatment and the Plan of Care for client's needing social work services; Provided ongoing assessment of client/family needs; Utilized appropriate community resources to achieve identified objectives; Participated in case conferences, staff meetings, inservice programs and utilization reviews as appropriate

Gentiva Health Services RehabWithoutWalls, Vernon Hills, Illinois
June, 2001 to July, 2006

Clinical/Medical Social Worker. Provided medical and clinical social work services within a community re-entry model of in-home and on-site rehabilitation services; Participated in interdisciplinary case teleconferences as necessary; Consulted with OT/PT/ST disciplines regarding clients psychosocial needs; Provided in-service training as requested

Private Clinical Social Work Practice, Park Ridge & Arlington Heights, Illinois
March, 1990 to present

Licensed Clinical Social Worker. Provide brief and long-term psychotherapy services for adolescents, adults, couples and families

Texas Research Institute of Mental Sciences, Houston, Texas
July, 1980 to September, 1982

Psychiatric Social Worker, Adult Outpatient Services. Provided psychosocial and diagnostic assessments of patients for inpatient and outpatient treatment based on OSM criteria as part of multi-disciplinary team; Provided brief and long-term psychotherapy services for individual adult outpatients

Family Care Services, Chicago, Illinois
February, 1991 to July, 1993

Clinical Social Worker. Provided home-based, family-centered psychotherapy and counseling services to children and families for a licensed child welfare agency under contract with the Department of Children and Family Services

TakeHeart Program, Chicago, Illinois
July, 1989 to July, 1992

Clinical Social Worker. Provided short-term behavioral modification therapy services related to modifying coronary-prone behavior in cardiac patients; Presented in-service educational training presentations to hospitals and community groups on coronary-prone behavior

University of Chicago, School of Social Service Administration, Chicago, Illinois
January, 1985 to September, 1985

Practitioner/Researcher, Elderly Support Project. Provided behavioral modification treatment and conducted clinical research experiments in behavioral treatment of the elderly and their families; Interviewed and trained subjects in their homes in family-centered behavioral intervention methods; Coded data; Conducted data analyses; Participated in public relations and dissemination of program results with participating agencies

Jewish Family and Community Service, Skokie, Illinois
June, 1983 to September, 1983

Clinical Social Worker, Outpatient Services. As summer intake worker, interviewed and evaluated walk-in clients; Completed psychosocial assessments; Crisis intervention; Psychosocial risk screening (assessed and interpreted data from medical records to determine need for possible social service intervention); Community resource linkage; Provided financial aid and counseling; Screened and assessed telephone inquiries for assistance; Provided brief and long-term psychotherapy for individuals and marital couples

Long Island Jewish Medical Center, Glen Oaks, New York
September, 1979 to May, 1980

Psychiatric Social Work Intern, Adult Outpatient Department. Provided brief and long-term individual, marital and family psychotherapy services for adult outpatients; Organized and ran a treatment group for alcoholic inpatients

Administrative Assistant, Central Intake Department. Conducted telephone interviews with new and prospective patients; Prepared applications for admission; Analyzed patient's financial data and insurance coverage for fee determination; Assisted department chief in administrative matters as requested

Creedmoor Psychiatric Center, Glen Oaks, New York
September, 1978 to May, 1979

Psychiatric Social Work Intern, Adult Inpatient Unit. Provided brief and long-term supportive psychotherapy services for psychotic and schizophrenic inpatients; Ran a remotivational group for severely regressed schizophrenic inpatients; Proposed, developed and implemented a community apartment living program for discharged young adult inpatients

Student Liaison, Queens Field Instructional Center. Assisted in planning, organizing and evaluating training workshops for a network of eight schools of social work; Organized and ran a student peer support group; Negotiated work demands of hospital administrative staff with learning needs of social work interns

RESEARCH EXPERIENCE

Biopsychosocial Developmental Risk Study, Park Ridge & Arlington Heights, Illinois
September, 1992 to present

Principal Investigator. Conduct independent clinical research into biological, psychological and social developmental risk/protective factors associated with violent criminal behavior and other mental/emotional disorders; Currently developing a manuscript of theory, methods, findings and applications related to above research

Ernst & Young, Chicago, Illinois
October, 1984 to February, 1989

Research Associate. Management Consulting Services, Health Care Planning Group. Development of strategic and program plans for hospitals in a variety of competitive situations; Market segmentation and competitor analyses of new business opportunities for major health care systems; Case mix planning analyses; Development of physician and nursing staffing arrangements; Evaluation of institutional demand, utilization, and volume trends; assessment of service area size, population demographics, socioeconomics, area providers, area health factors and growth potential for various multi-hospital health care systems: Certificate of need assistance: Analysis of medical staff practice patterns: Analysis of cost containment measures and rate-selling standards: Telephone survey interviews; Development of a national database of hospital and legislative data to facilitate certificate of need determination: Supervision of temporary personnel and audit staff; Literature reviews; Break-even analyses

Systems Developer. Complete responsibility for definition, design, development, and implementation of customized microcomputer-based financial and database systems for clients and in-house use-Responsibilities included: Assessment of user requirements; Definition of system alternatives; Recommendations for system enhancements based on user needs and/or production efficiency: Design of system architecture; Preparation of preliminary and detail design documentation; Development of work plans for implementation; Estimation of project time and costs; Preparation of progress reports on assigned work: Coding of programs, unit testing, and subsystem integration testing; Preparation of user manuals and source code documentation; Installation of programs; System performance testing; Development of training materials and formal and informal training in system use; Monitoring of system performance and troubleshooting; Communications with corporate personnel at all levels in regard to data processing needs: Evaluation and installation of pre-packaged software products

Chicago Urban League, Research and Planning Department, Chicago, Illinois
August, 1984 to October, 1984

Research Assistant. Chicago Health Care Assessment. Conducted field surveys for health care assessment study of Chicago's south side residents

University of Illinois, Department of Planning and Policy, Chicago, Illinois
May, 1984 to July, 1984

Research Assistant. Urban Community Study. Conducted field surveys for social services utilization trend study of Greater Chicago area

Michael Reese Hospital, Chicago, Illinois
June, 1984 to August, 1984

Consultant, Parent Alliance Study. Conducted in-home clinical interviews of couples as an independent research consultant to assess the qualitative aspects of the parental relationship; Administration of personality inventories and projective tests

Henry Booth House, Chicago, Illinois
November, 1983 to May, 1984

Research Consultant. Conducted research to study the potential for economic development opportunities for single-mother AFDC recipients; prepared final report of study findings (Women, Work & Welfare", Henry Booth House, May, 1984), which was distributed nationally

OTHER EXPERIENCE

Hull House Association, Chicago, Illinois
June, 1983 to January, 1984

Social Worker, Research & Advocacy Department. Assisted in organizing and coordinating Illinois Task Force on Child Support which was instrumental in passing and implementing wage withholding legislation for delinquent child support cases in Illinois; Assisted in developing and participated in provider's seminars and speaker's bureau, making presentations to community groups and employers regarding child support issues; Participated in drafting and editing state paternity legislation

Chicago Jobs Council, Chicago, Illinois
January, 1984 to January, 1985

Editor, "First Source" Newsletter. Developed, edited, wrote, and published community newsletter concerned with public policies affecting job targeting and affirmative action in Chicago

Houston Mental Health Association, Houston, Texas
July, 1981 to July, 1982

Chairperson, Parent Education Subcommittee. Wrote grant proposal for anti-victimization program to prevent sexual abuse of children. Grant was approved for $55,000. Program was implemented in 2,500 classrooms within the Houston Independent School District

Parenting Skills Workshop, Sugarland, Texas
April, 1981 to July, 1981

Consultant/Trainer. Developed, organized and implemented a private parenting skills training workshop for twenty couples, sponsored by the Settler's Park Homeowner's Association

Social Security Administration, Astoria, New York
February, 1976 to August, 1978

Service/Claims Representative. Initiated, adjudicated and serviced benefit claims to Social Security retirement, Medicare, disability, and SSI benefits

VOLUNTARY ACTIVITIES

Testified before Governor Ryan's Prison Review Board/Death Penalty Clemency Hearings, 2002
National Association of Social Workers Task Force on Violence 1995-1997
Testified before Attorney General's Violence to Children Task Force, 1996
Member, Advisory Board, Personal Touch Home Care, Inc., 1995-1997
Member, Advisory Board, Home Health Care, Inc., 1992-1 996
Member, Ethics Committee, Home Health Care, Inc. 1992 to 1996
Member, Utilization Review Committee, Home Health Care, Inc., 1995-1996
Member, Utilization Review Committee, Gentiva Health Services, 1995 to 2006
CAN, Channel 3, "Lifestyle With Pat Cheffer", Chicago, Illinois, 1991
Presenter at Ohio State University Conference on Doctoral Research in Social Work, 1989
Illinois Task Force on Child Support, 1983-1984
Parent Education Subcommittee, Houston mental Health Association, 1981-1 982
Project on Prevention of Mental Illness, Texas Department of Mental Health and Retardation, 1981-1982
KHOU-TV, 'The Warner Roberts Show", Houston Texas, 1981

PUBLICATIONS

Savarese, G.W. (1984). Women, work & welfare. Chicago, Illinois: Henry Booth House.

Savarese, G.W. (1989), A family-based approach to treatment of the elderly., In Social work practice with populations at risk: Proceedings from the fifth national symposium on doctoral research and social work practice. The Ohio State University, College of Social Work, November 8-9, p. 129-142.

MEMBERSHIPS/CERTIFICATIONS/LICENSES

National Association of Social Workers
Academy of Certified Social Workers
Licensed Clinical Social Worker, Doctorate, State of Illinois
American Association of Social Workers in Home Health Care
American Heart Association, Certified CPR & AED Program
Past Registered Speaker, American Heart Association's Speaker's Bureau

EXHIBIT

"2"

Code of Ethics in English *Code of Ethics* in Spanish

Code of Ethics
of the National Association of Social Workers

Approved by the 1996 NASW Delegate Assembly and revised by the 2008 NASW Delegate Assembly

The 2008 NASW Delegate Assembly approved the following revisions to the NASW Code of Ethics:

1.05 Cultural Competence and Social Diversity

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.
(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

4.02 Discrimination

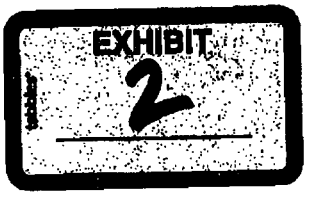
Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national
origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

6.04 Social and Political Action

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

close window

Preamble



The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual wellbeing in a social context and the wellbeing of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. The Code identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code*, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code's* values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and

standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code*, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agencybased or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this Code. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: *Service*

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*
Social workers elevate service to others above selfinterest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: *Social Justice*

Ethical Principle: *Social workers challenge social injustice.*
Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*
Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible selfdetermination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: *Importance of Human Relationships*

Ethical Principle: *Social workers recognize the central importance of human relationships.*
Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the wellbeing of individuals, families, social groups, organizations, and communities.

Value: *Integrity*

Ethical Principle: *Social workers behave in a trustworthy manner.*
Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*
Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the wellbeing of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 SelfDetermination

Social workers respect and promote the right of clients to selfdetermination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to selfdetermination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable,

social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social workerclient relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to thirdparty payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack DecisionMaking Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

1.16 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in feeforservice settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.
(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.
(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the wellbeing of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the wellbeing of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client wellbeing.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.

(c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an

allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the *NASW Code of Ethics* and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the *NASW Code of Ethics*.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 LaborManagement Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labormanagement disputes, job actions, or labor strikes should be guided by the profession's values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.

(c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations

(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.

(c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.

(d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.

(e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

(d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.

(e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' wellbeing, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

(f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.

(g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.

(h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.

(i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.

(j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

(k) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

(l) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(m) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(n) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(o) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(p) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

National Association of Social Workers, 750 First Street, NE • Suite 700, Washington, DC 20002-4241.
© 2013 National Association of Social Workers. All Rights Reserved.

EXHIBIT

"3"

NASW

EXHIBIT
3
294

NASW Standards for

Clinical Social Work

in Social Work Practice

National Association of Social Workers

Elvira Gajoce Silva, DSW, ACSW

NASW President

El Paso, TX

Elizabeth J. Clark, PhD, ACSW, MPH

Executive Director

Clinical Social Work Standards Committee

Doris Jones, LCSW, ACSW, BCD, Chair

Patricia Herrera Thomas, LCSW, LCSW

Jared Linde, LCSW

Mary Ann Nulty, LCSW, CSW, RIB, DAPA

Carol Seacord, ACSW, LCSW, BCD

NASW Staff

Toby Walmiller, ACSW

Tracy Whitaker, ACSW

Nancy Bateman, LCSW, C

Miriam Coleman, MSW, LICSW, CT

© 2011 National Association of Social Workers
All Rights Reserved

Contents

4 Overview of the Standards

7 Introduction

8 Goals of the Standards

9 Definitions

11 Standards for Clinical Social Work Practice

11 Standard 1: Ethics and Values

12 Standard 2: Specialized Practice Skills and Interventions

14 Standard 3: Referrals

14 Standard 4: Accessibility to Clients

15 Standard 5: Privacy and Confidentiality

16 Standard 6: Supervision and Consultation

17 Standard 7: Professional Environment and Procedures

18 Standard 8: Documentation

18 Standard 9: Independent Practice

19 Standard 10: Cultural Competence

20 Standard 11: Professional Development

21 Standard 12: Technology

22 References

Standards

for Clinical Social Work in Social Work Practice

Standard 1. Ethics and Values
Clinical social workers shall adhere to the values and ethics of the social work profession, utilizing the NASW *Codes of Ethics* as a guide to ethical decision making.

Standard 2. Specialized Practice Skills and Intervention
Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical intervention with individuals, families, and groups.

Standard 3. Referrals
Clinical social workers shall be knowledgeable about community services and make appropriate referrals, as needed.

Standard 4. Accessibility to Clients
Clinical social workers shall be accessible to clients during nonemergency and emergency situations.

Standard 5. Privacy and Confidentiality
Clinical social workers shall maintain adequate safeguards for the private nature of the treatment relationship.

Standard 6. Supervision and Consultation
Clinical social workers shall maintain access to professional supervision and/or consultation.

Standard 7. Professional Environment and Procedures
Clinical social workers shall maintain professional offices and procedures.

Standard 8. Documentation
Documentation of services provided to or on behalf of the client shall be recorded in the client's file or record of services.

Standard 9. Independent Practice
Clinical social workers shall have the right to establish an independent practice.

Standard 10. Cultural Competence
Clinical social workers shall demonstrate culturally competent service delivery in accordance with the *NASW Standards for Cultural Competence in Social Work Practice*.

Standard 11. Professional Development
Clinical social workers shall assume personal responsibility for their continued professional development in accordance with the *NASW Standards for Continuing Professional Education* and state requirements.

Standard 12. Technology
Clinical social workers shall have access to computer technology and the Internet, as the need to communicate via e-mail and to seek information on the Web for purposes of education, networking, and resources is essential for efficient and productive clinical practice.

Adopted by the NASW Board of Directors
June, 2005.

Introduction

Clinical social workers represent the largest group of behavioral health practitioners in the nation. They are often the first to diagnose and treat people with mental disorders and various emotional and behavioral disturbances. Clinical social workers are essential to a variety of client-centered settings, including community mental health centers, hospitals, substance use treatment and recovery programs, schools, primary health care centers, child welfare agencies, aging services, employee assistance programs, and private practice settings.

Clinical social work has a primary focus on the mental, emotional, and behavioral well-being of individuals, couples, families, and groups. It centers on a holistic approach to psychotherapy and the client's relationship to his or her environment. Clinical social work views the client's relationship with his or her environment as essential to treatment planning.

Clinical social work is a state-regulated professional practice. It is guided by state laws and regulations. In most instances, clinical social workers are required to have the following credentials:

- a master's degree from a social work program accredited by the Council on Social Work Education
- a minimum of two years or 3,000 hours of post-master's degree experience in a supervised clinical setting
- a clinical license in the state of practice.

Clinical social work is broadly based and addresses the needs of individuals, families, couples, and groups affected by life changes and challenges, including mental disorders and other behavioral disturbances. Clinical social workers seek to provide essential services in the environments, communities, and social systems that affect the lives of the people they serve.

Goals of the Standards

Clinical social workers are committed to the delivery of competent services to individuals, families, couples, and groups. Therefore, they shall recognize the client's role in his or her treatment planning and the client's right to have a knowledgeable, skilled practitioner who is guided by sound ethical practice.

These *Standards for Clinical Social Work Practice* set forth by the National Association of Social Workers (NASW) are intended to guide clinical social workers in all clinical settings. Specifically, the goals of the standards are to:

- maintain or improve the quality of services provided by clinical social workers
- establish professional expectations to assist social workers in monitoring and evaluating their clinical practice
- provide a framework for clinical social workers to assess responsible, professional behavior
- inform consumers, government regulatory bodies, and others about the professional standards for clinical social work practice.

The scope of clinical social work extends across many practice settings and populations. It is anticipated that these standards will reinforce and support current clinical practice in all settings, while affirming the value of clinical social work services as a discrete practice area.

Definitions

Client/Patient/Consumer

Social workers generally use the term "client" to refer to the individual, group, family, or community that seeks or is provided with professional services. The client is often seen as both the individual and the client system or those in the client's environment. The term "consumer" is also used in settings that view the client as the consumer, that is, one capable of deciding what is best for her or himself and encourages self-advocacy and self-judgment in negotiating the social service and welfare system. The term "patient" is more commonly used by social workers employed in health care settings (Barker, 2003). The term patient may also be used for insurance reimbursement purposes in health and mental health settings.

Clinical Social Work

Clinical social work is the professional application of social work theory and methods to the diagnosis, treatment, and prevention of psychosocial dysfunction, disability, or impairment, including emotional, mental, and behavioral disorders (Barker, 2003).

Counseling

This is a procedure that is often used in clinical social work and other professions to guide individuals, families, couples, groups, and communities by such activities as delineating alternatives, helping to articulate goals, and providing needed information (Barker, 2003).

Person-in-Environment Perspective

This orientation views the client as part of an environmental system. It encompasses reciprocal relationships and other influences between an individual, relevant others, and the physical and social environment (Barker, 2003).

Psychodynamic

This word pertains to the cognitive, emotional, and volitional mental processes that consciously and unconsciously motivate an individual's behavior. These processes are the product of the interplay among a person's genetic and biological heritage, the sociocultural milieu, past and current realities, perceptual abilities and distortions, and his or her unique experiences and memories (Barker, 2003).

Psychotherapy

Psychotherapy is a specialized, formal interaction between a social worker or other mental health professional and a client (either individual, couple, family, or group) in which a therapeutic relationship is established to help resolve symptoms of mental disorder, psychosocial stress, relationship problems, and difficulties in coping in the social environment. Types of psychotherapy include,

but are not limited to family therapy, group therapy, cognitive–behavioral therapy, psychosocial therapy, and psychodrama (Barker, 2003).

Therapy

This is a systematic process designed to remedy, cure, or abate some disease, disability, or problem. This term is often used by social workers as a synonym for individual psychotherapy, conjoint therapy, couples therapy, psychosocial therapy, or group therapy (Barker, 2003).

Standards for Clinical Social Work in Social Work Practice

Standard 1. Ethics and Values

Clinical social workers shall adhere to the values and ethics of the social work profession, utilizing the NASW *Code of Ethics* as a guide to ethical decision making.

Interpretation

The social work mission is rooted in six core values: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 1999). All social workers have a responsibility to embrace these values as a service to clients, the profession, self, colleagues, and society. In delivering clinical social work services, the social worker's primary responsibility is to his or her client. Clinical social workers shall acknowledge the right of clients to receive competent psychosocial services and demonstrate a commitment to act on professional judgment and convictions,

which are informed by the NASW *Code of Ethics* (1999).

Clinical social workers shall be prepared for the challenges that encompass the assessment and treatment of people with mental disorders and behavioral or emotional disturbances. This includes maintaining a commitment to the client while simultaneously demonstrating responsibility to the practice setting, society, and local, state, and federal policies and regulations governing the social worker's clinical practice. In the event that conflicts arise among competing interests, social workers are directed to the NASW *Code of Ethics* as one of the reference points for decision making. Services should only be provided in a setting in which the professional relationship can be maintained. Clinical social workers should adhere to the NASW *Code of Ethics* with regard to limits on private and/or dual relationships with clients.

Standard 2. Specialized Practice Skills and Interventions

Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical interventions with individuals, families, couples, and groups.

Interpretation

Drawing on knowledge of systems theory, person-in-environment orientation, psychodynamic theory, interpersonal dynamics, and family systems, clinical social workers shall be familiar with social, psychological, cultural, and health factors that influence the mental, emotional, and behavioral functioning of the client. They

shall have knowledge of theories of personality and behavior and be aware of sociocultural and environmental influences, as well as conditions that have an impact on the physical and emotional state of the client.

In addition to the above, clinical social workers shall have the ability to:

- establish and maintain a relationship of mutual respect, acceptance, and trust
- gather and interpret social, personal, environmental, and health information
- evaluate and treat problems within their scope of practice
- establish achievable treatment goals with the client
- facilitate cognitive, affective, and behavioral changes consistent with treatment goals
- evaluate the effectiveness of treatment services provided to the client
- identify appropriate resources and assessment instruments, as needed
- advocate for client services
- collaborate effectively with other social work or allied professionals, when appropriate.

When additional knowledge and skills are required to address clients' needs, the clinical social worker shall seek appropriate training, supervision, or consultation, or refer the client to a professional with the appropriate expertise. Clinical social workers shall limit the scope of their practice to those clients for whom they have the knowledge, skill, and resources to serve. They shall be accountable for all aspects of their professional judgment, behavior, and decisions.

Standard 3. Referrals

Clinical social workers shall be knowledgeable about community services and make appropriate referrals, as needed.

Interpretation

To ensure that clients receive optimal psychosocial services, it is sometimes beneficial to collaborate or coordinate services with appropriate community programs to strengthen or improve the continuity of care. Clinical social workers shall be knowledgeable about available community resources and advocate on behalf of the client for appropriate services. The clinical social worker shall maintain collaborative contacts with social work or other related professionals and make appropriate referrals, as needed. The clinical social worker shall not share information about the client without the client's informed consent or as otherwise indicated in Standard 5.

Standard 4. Accessibility to Clients

Clinical social workers shall be accessible to their clients.

Interpretation

Clinical social workers shall be available to provide clinical services to clients during regularly scheduled appointment times or sessions. In addition, the clinical social worker shall develop emergency plans or be available to the client for emergency coverage during vacations, holidays, illnesses, and at other times when the office may be closed. Arrangements or plans and procedures for emergency coverage shall be made in partnership with competent mental health

professionals or reputable institutions and should be discussed with the client at the initial face-to-face interview.

In addition, the office setting should be accessible and/or have helping devices for persons with disabilities, or office limitations should be discussed prior to scheduling appointments.

Standard 5. Privacy and Confidentiality
Clinical social workers shall maintain adequate safeguards for the private nature of the treatment relationship.

Interpretation:
Confidentiality is a basic principle of social work intervention. It ensures the client that what is shared with the social worker will remain confidential, unless there is an ethical or legal exception. All information related to or obtained from the client by the clinical social worker shall be viewed as private and confidential. Clinical social workers shall be familiar and comply with local, state, and federal mandates governing privacy and confidentiality, such as the federal Health Insurance Portability and Accountability Act (HIPAA) requirements and state medical records laws.

Information obtained by the social worker from or about the client shall be viewed as private and confidential, unless the client gives informed consent for the social worker to release or discuss the information with another party. There may be other exceptions to confidentiality as required by law or professional ethics. Social workers should be

familiar with national, state, and local exceptions to confidentiality, such as mandates to report when the client is a danger to self or others and for reporting child or elder abuse and neglect. The clinical social worker shall advise the client of confidentiality limitations and requirements at the beginning of treatment.

Professional judgment in the use of confidential information shall be based on best practice, as well as legal, and ethical considerations.

Standard 6. Supervision and Consultation
Clinical social workers shall maintain access to professional supervision and/or consultation.

Interpretation
Clinical social workers should ensure that professional social work supervision is available to them in a clinical setting for the first five years of their professional experience (NASW, 2004). If clinical social worker supervisors are not available or accessible, case consultation may be obtained from qualified professionals of other related disciplines. Those clinical social workers with more than five years of clinical experience shall use consultation on an as-needed, self-determined basis. Clinical social workers shall adhere to state and federal statutes and regulations regarding supervision and consultation in their states of practice.

When appropriate, clinical social workers should offer their expertise to individuals, groups, and organizations, as well as offer training and mentoring opportunities to

beginning social workers or those making the transition into clinical social work. In addition, experienced clinical social workers who are able should offer supervision to social workers seeking state licensure for clinical social work practice.

Standard 7. Professional Environment and Procedures

Clinical social workers shall maintain professional offices and procedures.

Interpretation

Agencies providing clinical social work services and clinical social workers in private or independent practice shall develop and implement written policies that describe their office procedures, such as the client's rights, including the right to privacy and confidentiality; notices and authorizations; procedures for release of information, fee agreements; procedures for payment; cancellation policy; and coverage of services during emergency situations or when the clinical social worker is not available. These policies shall be made available to and reviewed with each client at the beginning of treatment. Clinical social workers should maintain appropriate liability insurance and have a current working knowledge of risk management issues.

In addition to the above, the treatment setting shall be properly maintained to ensure a reasonable degree of comfort, privacy, and security for the social worker and the client.

Standard 8. Documentation

Documentation of services provided to, or on behalf of, the client shall be recorded in the client's file or record of services.

Interpretation

Clinical social workers must document all services rendered to clients and keep the records in a secure location, maintaining them as private and confidential records. Documentation must reflect an accurate account of services. Progress notes, reports, and summaries of services shall be regularly recorded in the client's file and be consistent with all applicable local, state, and federal statutory, regulatory, or policy requirements. Records must meet current federal provisions regarding privacy, security, and electronic transactions standards and code sets.

Standard 9. Independent Practice

Clinical social workers shall have the right to establish an independent practice.

Interpretation:

Clinical social workers may establish an independent solo or group practice. When doing so, they shall ensure that all services, including diagnostic and treatment planning, meet professional standards. When clinical social workers employ staff, they, as employers, bear responsibility for the competency of all services provided; maintaining clinical and ethical standards; and upholding all local, state, and federal regulations.

To avoid conflicts of interest, clinical social workers who are both employed by agencies

and have independent practices shall not refer agency clients to themselves without prior agreement with the agency and consent of the client. In addition, the clinical social worker shall have offered alternative options to the client, such as transferring the client to another treatment provider within the agency or terminating services.

Clinical social workers in private or independent practice may bill third-party payers or their clients for services rendered. Clients shall be provided with all invoices and receipts in a timely manner. When a client can no longer afford services—or a third-party payer or an agency terminates services—an alternative mutually agreed upon with the client may be instituted, which could include, for example, a referral, termination of services, a sliding scale, or pro bono services. If services continue, consideration must be given to any applicable federal or state laws and regulations as well as insurance or managed care contracts that may limit the type of continuing care.

When a client chooses to terminate treatment, the clinical social worker will offer to aid the client in exploring barriers to treatment and re-examine the treatment plan to help the client reach termination constructively. When appropriate, the clinical social worker shall refer the client to another qualified treatment provider.

Standard 10. Cultural Competence

Clinical social workers shall demonstrate culturally competent service delivery in accordance with the *NASW Standards for Cultural Competence in Social Work Practice*.

Interpretation

The increasingly diverse population seeking psychosocial services requires that clinical social workers raise their awareness and appreciation of cultural differences. Clinical social workers shall have, and continue to develop, specialized knowledge and understanding about history, traditions, values, and family systems as they relate to clinical practice with individuals, families, and groups. Clinical social workers shall be knowledgeable about and demonstrate practice skills consistent with the *NASW Standards for Cultural Competence in Social Work Practice* (2001). In addition, clinical social workers need to be knowledgeable about the deleterious effects of racism, sexism, ageism, heterosexism or homophobia, anti-Semitism, ethnocentrism, classism, and disability-based discrimination on clients' behavior, mental and emotional well-being, and course of treatment. Clinical social workers must also recognize racial, ethnic, and cultural differences that may be interpreted as barriers to treatment and develop skills to ameliorate such barriers.

Standard 11. Professional Development

Clinical social workers shall assume personal responsibility for their continued professional development in accordance with the *NASW Standards for Continuing Professional Education* and state requirements.

Interpretation

To practice effectively, clinical social workers must remain knowledgeable about emerging theories and interventions, best practice models in the social work profession, and changes in policies and regulatory reforms

such as the HIPAA regulations. Clinical social workers shall seek to enhance their skills and understanding by staying abreast of research to ensure that their practice reflects the most current knowledge. Clinical social workers should also seek continuing education about risk management and professional liability issues.

Numerous opportunities in professional development are available through NASW and other professional organizations or institutions, coalitions, and service agencies at local, state, and national levels. Clinical social workers should regularly participate in and contribute to professional conferences and training activities and contribute to and promote professional publications.

Standard 12. Technology

Clinical social workers shall have access to computer technology and the Internet, as the need to communicate via e-mail and to seek information on the Web for purposes of education, networking, and resources is essential for efficient and productive clinical practice.

Interpretation

Clinical social workers are increasingly using the Web, computers, and other electronic technology to improve the quality of services for clients, to communicate with other professionals, and for documentation purposes. Clinical social workers should keep abreast of electronic changes that may affect practice. Technology may be integrated into clinical practice; however, appropriate safeguards for client privacy shall be used.

Clinical social workers should engage in ongoing training in technology applications relevant to clinical social work practice including assessment and treatment, research, policy, education, and resource tracking and development.

Free information on the Standards is located on the NASW Web site: www.socialworkers.org.

Purchase full document from NASW Press at 1.800.227.3590.

References

Barker, R. L. (2003). *The social work dictionary* (4th ed.). Washington, DC: NASW Press.

Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 110 Stat. 1936.

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers*. Washington, DC: NASW Press.

National Association of Social Workers. (2001). *NASW standards for cultural competence in social work practice*. Washington, DC: Author.

National Association of Social Workers. (2002). *NASW standards for continuing professional education*. Washington, DC: Author.

National Association of Social Workers. (2004). *Clinical social workers in private practice: A reference guide*. Washington, DC: Author.

EXHIBIT

"4"

NASW

EXHIBIT
4
319

NASW Standards for

Social Work Practice

in Health Care Settings

National Association of Social Workers

Hobart Alpert, MSW, ACSW

NASW Board (2005-2008)

President, ACSW, MPH

Executive Director

President-Elect, ACSW, MSW

Nancy Angell, MSW, BCD

Nancy Kochman, MSW

Judy Cox, BCD, ACSW, MSW

Sandra Hill, ACSW, MSW

Carolle Marshall, MSW, ACSW, BCD

Hillary Rodham Clinton, MSW, ACSW, ACSW

NASW Staff

Mary Bartholomew, ACSW

Evelyn Blumenthal, ACSW

Karen Walsh, ACSW, ACSW

Copyright © 2006 National Association of Social Workers
All Rights Reserved

Contents

5 Introduction

6 Background

8 Social Work Guiding Principles

9 Definitions

14 Standard 1: Professional Practice

14 Standard 2: Ethics and Values

15 Standard 3: Human Dignity

17 Standard 4: Cultural Competence

18 Standard 5: Confidentiality

19 Standard 6: Knowledge

20 Standard 7: Assessment

21 Standard 8: Intervention and Treatment Planning

22 Standard 9: Case Management

24 Standard 10: Empowerment and Advocacy

24 Standard 11: Client and Community Education

25 Standard 12: Teamwork and Collaboration

26 Standard 13: Documentation

27 Standard 14: Research

28 Standard 15: Performance Improvement

29 Standard 16: Access to Information and Technology

30 Standard 17: Professional Development, Training and Leadership

31 Standard 18: Qualifications

31 Standard 19: Continuing Education

32 Standard 20: Supervision

33 Standard 21: Leadership

34 References

36 Acknowledgements

Introduction

The constant growth, demands, and changes in health care have had a serious impact on the viability and need for social workers in all areas and settings of health care. More than 15 percent of the population or 45 million people in the United States were without health insurance coverage during 2003 (U.S. Census Bureau, 2004). Access to timely, comprehensive, and equitable health care for individuals in the United States varies considerably, with significant percentages of many populations having only limited access to health care. The growth in medical technology has offered hope and improved quality of life to many people; yet, the advances in technology have also raised health care costs and introduced social, legal, and ethical dilemmas for individuals, families, and health care providers. These psychosocial implications of health care are what social workers are trained to address.

Currently, health care social workers provide services across the continuum of care and in various settings. Social workers are present in public health, acute, and chronic care settings providing a range of services including health education, crisis intervention, supportive counseling, and case management. In response to critical incidents that are both global and national, health care social workers are increasingly trained to provide interventions to prepare for and respond to traumatic events and disasters.

The health care system in the United States is complex and multidisciplinary in nature, and

may include a network of services such as diagnosis, treatment, rehabilitation, health maintenance, and prevention provided to individuals of all ages and with a range of needs. Multiple sources of financing, ranging from Medicare and Medicaid to private insurance, provide further challenges. Many consumers lack health insurance or have inadequate coverage, which causes financial stress on consumers and providers.

Professional social workers are well equipped to practice in the health care field, because of their broad perspective on the range of physical, emotional, and environmental factors that have an effect on the well-being of individuals and communities. These standards are developed to meet the needs of social workers in multiple health care practice settings and to help the public understand the role of the professional social worker. The National Association of Social Workers (NASW) recognizes that standards alone cannot improve the quality of practice unless they are disseminated and implemented at the practice level. Client satisfaction and improved quality of care result when social workers and administrators recognize and use these standards.

Background

Social workers have been involved in the health care field since the turn of the 20th century. The profession's earliest concerns were with making health care services available to the poor and with improving social conditions that bred infectious diseases such as

tuberculosis. As the social work role expanded, social workers joined other health professions in the delivery of high quality services. Today, social workers can be found in every component of the health care system. In 1977, NASW published *Standards for Hospital Social Services*. In 1980, the *Standards for Social Work in Health Care Settings* were developed and replaced the hospital standards. Between 1981 and 1982, the NASW Board of Directors approved the new standards, and three subsections were developed, approved, and added to the health care standards. The subsections included the *Standards for Social Work in Developmental Disabilities*, *Standards for Social Work in End-Stage Renal Disease Treatment Settings*, and *Standards for Social Work in Public Health Settings*.

In the early 1980s, a capitated system for payment of Medicare services in acute health care settings, known as diagnostic-related groups (DRGs), was initiated by the federal government. This initiative, generically known as managed care, fundamentally altered health care financing for both public and private health care systems. Managed care focused on reducing the length of stays in acute care facilities, and this led to a fundamental shift in the role of social workers in acute health care. Social workers became more focused on planning for an individual's transition to home or to another level of care. Social work services disappeared entirely from some health care settings due, in part, to a lack of data demonstrating the efficacy of social work services and loss of funding for those services. Yet, in other settings, social workers have prospered, gaining recognition through the

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508

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

v.

Charlotte-Mecklenburg Hospital
Authority d/b/a Carolinas Medical
Center; South Carolina Department of
Social Services and Bruce Bryant, as
the Constitutional Office of the Sheriff
of York County, the York County
Sheriff's Department, and York County

Of whom

Charlotte-Mecklenburg Hospital
Authority d/b/a Carolinas Medical
Center is the ..... Respondent.

RECORD ON APPEAL (VOLUME 2)

Monteith P. Todd
Robert E. Horner
Sowell Gray Stepp & Laffitte, LLC
1310 Gadsden Street
Post Office Box 11449
Columbia, SC 29211
(803) 929-1400

S. Randall Hood
Deborah G. Casey
Lara Pettiss Harrill
Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800

Attorneys for Respondents, The Charlotte Mecklenburg Hospital Authority d/b/a Carolinas Medical Center

Duane M. Shaw
Nathan J. Sheldon
Shaw Law Firm
1169 Ebenezer Road
Rock Hill, SC 29732
(803) 329-4200

Attorneys for Appellant Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to Owen C.

January 7, 2014
Rock Hill, South Carolina

provision of specialized services in multiple health care arenas such as palliative care, ethics, ambulatory care, rehabilitation, and geriatric services.

The *NASW Standards of Social Work Practice in Health Care Settings* are based on the consensus of expert health care social workers from across the country and are designed to enhance social workers' knowledge, skills, values, and methods necessary to work effectively with individuals, families (broadly defined), health care providers, and the community when practicing in health care settings.

Social Work Guiding Principles

The basic values of social work, from promoting an individual's right to self-determination to having an attitude of empathy for the individual, are the foundation of social work practice. When confronting dilemmas or needs in health care, social workers can use the principle of client self-determination in matters where clients or their proxies are faced with such issues (NASW, 2004).

Social workers have skills in cultural awareness and cultural competence, in which social work practice respectfully responds to, and affirms, the worth and dignity of people of all cultures, languages, classes, ethnic backgrounds, abilities, religions, sexual orientation, and other diverse features found in individuals (NASW, 2001). Social workers look at the person-in-environment, including all of the

factors that influence the total health care experience. Social workers practice at the macro and micro level of health care and thus have the ability to influence policy change and development at local, state, and federal levels and within systems of care. Social work research in health care benefits not only individuals and families, but also the very existence, effectiveness, and validation of the profession. These standards offer a guide for social workers practicing in any health care setting.

Definitions

Bioethics

Bioethics is the analysis and study of moral, legal, social, and ethical considerations involving the biological and medical sciences. Many health care settings have organized forums such as bioethics committees, institutional review boards, or consultation processes to address ethical dilemmas and questions.

Biopsychosocial–spiritual Perspective

The biopsychosocial–spiritual perspective recognizes that health care services must take into account the physical or medical aspects of ourselves (bio); the emotional or psychological aspects (psycho); the sociocultural, sociopolitical, and socioeconomic issues in our lives (social); and how people find meaning in their lives (spiritual). This approach draws from the strengths perspective of social work practice. The strengths perspective recognizes an individual's strengths and abilities to cope

with problems; and awareness and use of the client's strengths is part of the foundation of social work theory and practice. The strengths perspective is seen in social work practice through our role of enhancing personal strengths and resources, helping clients solve both interpersonal and environmental problems, and helping clients mobilize for change. The strengths perspective helps clients use their past successful choices and behaviors, skills, and insights to resolve or "work through" a current crisis (Tomaszewski, E. P., 2004; Saleebey, 2003).

Case Management

Case management, sometimes used interchangeably with care management, is the collaborative process of assessment, planning, and facilitation for options and services to meet an individual's complex needs. When appropriate, this would include arranging, coordinating, monitoring, evaluating, and advocating on behalf of the client and/or his or her family for the multiple services needed from a variety of social service and health care agencies. Case management addresses both the individual client's biopsychosocial-spiritual status (micro level) as well as the state of the social systems in which the services operate (macro level).

Client/Patient/Consumer

These terms refer to the person receiving care and treatment from physicians and allied health care personnel. Social workers generally use the term client to identify the individual, group, family, or community who seeks or is provided with professional services. The client is often seen as both the individual and the

client system or those in the client's environment. The term consumer is also used in settings that view the client as the consumer, that is, one capable of deciding what is best for her or himself and encourages self-advocacy and self-judgment in negotiating the social service and welfare system. The term *patient* is more commonly used by social workers employed in health care settings (Barker, 2003).

Continuum of Care

The care continuum includes the specialized health, social work services, rehabilitative, and home-based services that a seriously or chronically ill or injured person might need. This continuum addresses both the medical care and the other services that promote the patients' well-being (Barker, 2003).

Continuity of Care

Continuity of care ensures the coordination of care within an organization or across different agencies or settings to reduce duplicate services, to address gaps in existing services, and to ensure consistent and continuous services for the client as they transition in care or are discharged.

Disabling Condition

A disabling condition is considered a temporary or permanent reduction in a client's capacity or functioning based on the inability to perform some activities that most others can perform. A disabling condition can be congenital, can be the result of an accident or trauma, or more frequently is the result of chronic illness (that is, diabetes, hypertension).

Health Care Settings

Health care settings are practice areas in which assessment, care, and treatment address the physical, mental, emotional, and social well-being of the person; and address prevention, detection, and treatment of physical and mental disorders with the goal of enhancing the person's biopsychosocial and spiritual well-being. The health care setting includes personnel who provide the necessary services (for example, physicians, social workers, nurses, hospital attendants); appropriate service delivery facilities (for example, hospitals, hospice, assisted living, medical centers, and outpatient clinics); and educational and environmental facilities that work to help prevent disease (Barker, 2003).

Health Planning

Health planning is conducted in government organizations, medical and research organizations, and educational institutions and in prevention, early intervention, treatment, and follow-up. Planning should involve determining and ensuring the number of necessary health care personnel presently and in the future, and how to both finance and control costs. It includes where to locate facilities, how to provide the most effective means of service delivery, and how to provide services in a cost effective manner (Barker, 2003; NASW, 1987).

Managed Care

Managed care is a process designed to manage health care costs primarily through the private sector, although Medicaid's or Medicare's capitated systems are a form of managed care. It is a technique used by insurance carriers

and characterized by preauthorization to qualify the patient for particular services; preauthorization for a given amount of care; review of treatment and patient response(s); utilization review; predischarge planning to ensure the patient is ready to be released (having received the care required) and has an aftercare plan. Managed care plans include preferred provider organizations (PPOs), health maintenance organizations (HMOs), or a combined version through a point-of-service (POS) plan.

Medicaid

Medicaid is a government-funded health insurance program that provides payment for hospital, nursing home, home care, dental, and medical services to people who meet disability guidelines and income eligibility requirements. The Medicaid program is a shared federal/state/county program and although there are certain federal standards, states have a choice of benefits which they can choose to cover or not. Medicaid, administered by the Centers for Medicare and Medicaid Services (CMS), is the largest source of funding for medical and health-related services for people with a limited income (Centers for Medicare and Medicaid Services, 2004b).

Medicare

Medicare is a national health care program, administered by CMS, for most people age 65 and older, people with a variety of disabilities who are under age 65, and people with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant (CMS, 2004a). Medicare is funded through a combination of

employer–employee contributions (as part of the person's Social Security), from earmarked taxes, and general federal revenues. Since Medicare is a federal program, benefits are the same in all 50 states.

Public Health Model

The Public Health Model of services focuses on the health of the individual, the family, and the larger community or general public and is administered by federal, state, and local agencies. The goal of programs, policies, and health care personnel is to prevent and treat disease, identify and eliminate environmental hazards, prolong life, and promote better health (Barker, 2003; NASW, 1987).

Standards for Social Work Practice in Health Care Settings

Standard 1. Ethics and Values

Social workers shall have knowledge of and practice according to the guidelines established by the NASW *Code of Ethics* (NASW, 1999).

Interpretation

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs of people who are vulnerable, disenfranchised, oppressed, and living in poverty. The mission is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

In a health care system increasingly driven by technological advances, the ethical and moral questions and dilemmas raised for clients, families, and health care professionals are numerous and complex. Health care settings have designed a number of different systems to ensure ethical behavior among health care practitioners. Ethics committees are often used to provide "objective" reviews to health care providers and clients and families, when there is conflict between providers or providers, clients, and families. Institutional review boards are used to protect clients from the potential of experimentation in research projects. Social work supervision and peer consultation can also be used to discuss ethical issues facing practitioners.

Standard 2. Health Disparities

Social workers practicing in local, state, national, and international health care settings require knowledge and skills to help them recognize and address inequalities and injustices directed toward clients, organizations, and communities related to access to care and provision of health services.

Interpretation

Many social workers have historically delivered services as part of community-based organizations and public health programs to address health disparities among those who

are least likely to be able to gain access to adequate care. Social workers have an ethical obligation to address the health care needs of these groups and advocate for change to ensure access to care. Training of health care professionals to achieve a level of cultural competence—an understanding of practice patterns and attributes of diverse groups—is an essential part of basic and continuing education for all health care professionals, including social workers (Gilbert, 2003).

Health is a matter of both economics and social well-being. Both domestically and internationally, health care social workers strive to gain knowledge about health care: behavior, expenditures, reforms, systems, teams, insurance, health maintenance organizations, health protective behaviors, and more. Social workers also help clients to gain access to health care as they navigate between and among complex service delivery systems and entitlements.

Different entities shape public and global policies in every country. Therefore, social workers must keep abreast of policies to competently help clients and to assess physical, environmental, historical, situational, cultural, and structural factors that affect health care systems.

Accessibility to preventive, palliative, and curative health care depends largely on the client's ability to pay, and often, people cannot afford existing fees. In many nonprofit community-based clinics, services are provided on a "first come-first serve" basis (often with a long wait or long lines) and are limited by

a shortage of supplies and equipment. Increasingly, private systems of care emerge alongside public systems and other health care providers to care for the uninsured or underinsured who need health services, yet prefer to care for those who can pay fee-for-services. When these realities exist, social workers shall act as brokers, advocates, and mediators for clients.

Standard 3. Cultural Competence

Social workers shall develop and maintain an understanding of the history, traditions, values, and family systems of client groups as they relate to health care and decision-making. In compliance with the *NASW Standards for Cultural Competence in Social Work Practice* (NASW, 2001), social workers shall have a sensitivity to and awareness of the diversity in cultural groups and integrate this knowledge into their practice.

Interpretation

The importance of recognizing, respecting, and understanding other cultures and related health beliefs lays a foundation to build therapeutic alliances with clients and families. Social workers are responsible for self-reflection regarding the impact of their own cultural beliefs on their professional and personal life.

Social workers in health care shall approach each client and family interaction from a perspective of cultural respect and awareness. This implies reluctance to stereotype individuals based on assumed group similarities and seeks instead to ask individuals what aspects of their cultural experience are

meaningful in understanding a particular health care need. Social workers recognize that ethnic, cultural, spiritual, and religious factors can have an impact on health care choices and adherence to regimens of care.

Appreciation of cultural influences is especially important for clients at critical health junctures, such as birth, diagnosis of a major illness, and facing the end of life. Social workers have a responsibility to assist the client and family system in observing culturally meaningful practices whenever possible. When delivering culturally competent services, social workers should be guided by the *NASW Standards for Cultural Competence in Social Work Practice* (NASW, 2001).

Standard 4. Confidentiality

Health care social workers shall maintain appropriate safeguards for the privacy and confidentiality of client information.

Interpretation

Social workers must be familiar and comply with local, state, and federal mandates related to confidentiality. Professional judgment in the use of confidential information shall be based on best practice, ethical, and legal considerations (including the federal Health Insurance Portability and Accountability Act [HIPPA] regulations). Clients, families, and other professionals should be informed of the confidentiality limitations and requirements before services are initiated and in all phases of the health care experience.

Standard 5. Knowledge

Social workers in health care settings shall demonstrate a working knowledge of current theory and practice and integrate such information into practice.

Interpretation

The social worker uses knowledge about, and psychosocial implications of, illness, injury, and health conditions to provide social work services to clients and families to help them manage and cope with the impact of such health matters. Social workers have expertise in communication; navigating systems of care, resources, client and family coping skills; and the comprehensive impact of health conditions on the client. With the person-in-environment perspective, social workers look at all of the influences and aspects of a person's life to complete a thorough assessment and treatment plan with the client, family, and other health care professionals.

Essential areas of knowledge and understanding about health care include:

- the roles and functions of social work in health care
- the biopsychosocial needs of clients and families
- the physiological elements of illness and their impact on psychosocial functioning
- the psychological and spiritual needs of clients and families and how to ensure that they can be addressed
- community resources to assist clients and families
- the disparities across cultures and economic groups in gaining access to and funding for health care

- ethical and legal questions and dilemmas
- laws, regulations, and policies affecting clients, families, and social work practice
- the accreditation and regulatory standards governing settings providing health care
- evidence-based practices and social work research in health care
- the needs of special populations.

Standard 6. Assessment

Social workers shall provide ongoing assessment, including gathering comprehensive information to use in developing interventions and treatment strategies.

Interpretation

Assessment is a fundamental process of social work practice. Treatment and intervention strategies/plans require that social workers both assess and reassess client needs and modify plans accordingly. Social work assessments in health care settings include considering relevant biomedical, psychosocial, and spiritual factors and the needs of the individual client and the family (as defined by the client) (NASW, 2004).

A comprehensive, culturally competent assessment includes:

- past and current health status including genetic history of family health
- the impact of health conditions or treatments on cognitive, emotional, social, sexual, psychological, or physical functioning
- the impact on body image, intimacy, and sexuality

- social history, including current living arrangement and household environment
- work, school, or vocational history
- stage in the life cycle and related and relevant developmental issues
- cultural values and beliefs, including views on illness, disability, and death
- family structure and the client's role within the family
- social supports, including formal and informal support systems
- behavioral and mental health status and current level of functioning, including history, suicide risk, and coping styles
- financial resources, including access to and type of health insurance.

Comprehensive assessments shall address unique needs relevant to special populations, including children, people with severe and persistent mental illness, immigrants and refugees, people with substance use disorders, victims of violence or trauma, homeless people, and people with physical or psychiatric disabilities.

Standard 7. Intervention and Treatment Planning

Social workers implement intervention and treatment plans that promote client well-being and ensure a continuum of care. Planning shall be based on a comprehensive, culturally competent assessment with interdisciplinary input.

Interpretation

Intervention and treatment plans are steps identified by the health social worker, in collaboration with the client and with other

members of the team, to achieve objectives identified during assessment. Social workers shall be able to adapt practice techniques to best meet client needs within their health care setting to work effectively with individuals across the life-span, with different ethnicities, cultures, religions, socioeconomic and educational backgrounds, and across the range of mental health and disability conditions (NASW, 2004).

Intervention or treatment plans may include:

- strategies to address needs identified in the assessment
- information, referral, and education
- individual, family, or group counseling
- vocational, educational, and supportive counseling
- psychoeducational support groups
- financial counseling
- case management
- discharge planning
- interdisciplinary care planning and collaboration
- client and systems advocacy
- goals and objectives.

Standard 8. Case Management

Social work case management shall optimize client functioning. Case management facilitates collaboration among providers to address the client's biomedical and psychosocial needs to better provide efficient, appropriate, and beneficial health care services to a client with (often) multiple needs.

Interpretation

Social work case management requires the professional social worker to develop and maintain a therapeutic relationship with the client, which includes linking the client with resources that provide a range of services, resources, and opportunities to enhance successful quality outcomes for the client. Culturally competent case management is both micro and macro in nature and requires interdisciplinary care planning and collaboration with other professionals to maintain a team-oriented approach. Case management may include having regular meetings with the client and family and assisting the client to navigate systems.

The scope of services would include the following:

- psychosocial assessment, including diagnoses, interventions, and treatment plans
- financial assessment, planning, and intervention
- case facilitation
- patient and family counseling
- crisis intervention
- quality improvement
- resource brokering/referral/development
- continuity of care planning
- system integration
- outcome/practice evaluation
- teamwork/collaboration
- patient/family education
- patient/family advocacy

Standard 9. Empowerment and Advocacy
Social workers have a responsibility to advocate for the needs and interests of clients and client systems in health care, including advocating for larger system change to improve access to care and improved delivery of services.

Interpretation
Social workers have a special responsibility to advocate for the needs of the disenfranchised or the most vulnerable of the population at both the micro and macro levels. Social workers will identify barriers to services and actively seek to resolve them. The responsibility to advocate for quality improvement also implies a responsibility for health social workers to act as advocates to expand the role of the profession, develop leadership programs, and mentor new professionals.

Standard 10. Client and Community Education
Social workers act as educators for clients, families, the community, and other professionals regarding disease prevention, impact of illness and disease progression, advocacy for benefits, health maintenance, and adherence to treatment regimens.

Interpretation
Social workers have a formal role as educators. Social workers gain knowledge and expertise in the health practice setting from other professionals and from formal education, work, or teaching experience. They have the knowledge and skill to implement the principles of learning theories in education programs, activities, and resources. They

communicate and collaborate with departments and other staff to foster client education. They serve with other members of the health care team for program and resource development, planning, implementation, and evaluation.

Social workers use a variety of methods to define and identify learning needs of individuals and families. Assessment identifies the educational needs based on the expressed needs of individuals, family members, and significant others. The social worker identifies deficiencies in the knowledge base of the client and works with the client to obtain the needed information and resources. Social workers collaborate with the health care team to design educational activities to meet the client's needs, to deliver the activities in a method that facilitates the learning needed, and to evaluate the process in an integral, ongoing, and systematic manner.

Standard 11. Teamwork and Collaboration
Social workers shall participate in care teams, and collaborate with other professionals, volunteers, and groups in and outside of their practice setting to enhance all aspects of the client and family system's care.

Interpretation
Social workers participate in multiple care teams, which are typically interdisciplinary. These teams often provide comprehensive care and information in a client's home, in outpatient or inpatient health, and mental health care settings.

As part of such teams and collaborations, social workers shall demonstrate the ability to:

- understand the mission and functions of the service organization or group for which the social worker is employed
- understand the role of other relevant professions and organizations
- communicate and cooperate appropriately with other disciplines and agencies
- ensure that the social work role and responsibilities are clearly delineated and communicated to other members of the team
- ensure that the roles and responsibilities of each collaborating organization are clearly delineated and communicated
- advocate for changes in care that reflect the interests of the client and client system
- communicate the client's information in a respectful and objective manner and protect the client's confidentiality and privacy
- share leadership and decision-making functions

Standard 12. Workload

Health care social workers shall maintain a workload that allows for efficient and quality social work service delivery. The size of the social work staff shall represent the scope and the complexity of the organization and the nature and numbers of the populations served.

Interpretation

Both the health care organization or setting and the social work leader and staff have joint responsibility for establishing and maintaining a workload that allows for adequate and appropriate interventions and monitoring of

services and outcomes. A workload consists of any social work function performed for the purpose of the social work position, including direct practice, administration, policy, research, or education. The workload also reflects the demands of the population served and may include social work coverage outside of regular office hours. It is the joint responsibility of the organization and the social worker to resolve issues of workload concerns.

Standard 13. Documentation

Social workers shall maintain records or documentation of social work services, which reflect the client and client systems' pertinent information for assessment and treatment; social work involvement and outcomes with and for clients; and in accordance with care goals and legislative and administrative regulations and policies.

Interpretation

The importance of clear, concise, and organized documentation reflects the hallmark of quality social work services and often serves as the mode of communication between a social worker and other professionals and clients. There are core elements that need to be included and responsibilities to follow in record keeping. The elements and responsibilities of thorough and comprehensive documentation include the following:

- comprehensive assessment and services delivered to the client and client systems, including the development of a plan of care

- ongoing assessments, interventions, and treatment planning
- goals and planning that reflect an explicit statement of agreement with client, client systems, and team input
- referral sources and collaborations
- dates, times, and descriptions of client and client system contacts
- documentation of outcomes
- reason for case closure or transfer
- written permission to release and obtain information, where appropriate
- documentation of compliance with confidentiality rights and responsibilities
- documentation of receipts and disbursements

Standard 14. Research

Health care social workers shall understand research planning, methodology, evidence-based outcomes, and program evaluation.

Interpretation

Social workers have a responsibility to be familiar with the literature crucial to their area of practice. As professionals, social workers in all settings have a mandate to improve the knowledge of the field, and this can best be accomplished through participation in research activities.

Venues where health care social workers might help to develop, implement, or evaluate research include inpatient and outpatient hospital-based settings, community or home health agencies, and federally funded clinical trial research networks. Rich data sources that permit opportunities for quantitative and qualitative research exist within these entities.

Clinical trials (methodological assessments of the safety and efficacy of new treatments or new methods for administering existing treatments) help answer scientific questions and greatly depend on study participants' committed participation. Social workers may help physicians, nurses, pharmacists, and others recruit individuals and encourage study participation and adherence to medication regimens; they can also help clients manage problems that may hinder adherence and retention, such as challenging life circumstances and demands from family members.

Standard 15. Performance Improvement
Health care social workers shall be a part of ongoing, formal evaluation of their practice to assess quality and appropriateness of services, to improve practice, and to ensure competence.

Interpretation
Social workers are trained to facilitate improvements that alter the processes in which health care is delivered. They are ethically charged to promote process improvements that will enhance patient or consumer safety, satisfaction, efficient and effective care, and identify and promote best practices and equitable care on a multidisciplinary basis.

The evaluation of social work practice is a vital part of social work service delivery. The methods to evaluate such practice include peer review, self-evaluation, supervision, and other research methods. Increasingly, social work outcomes from evaluations are used for position justification, performance review,

social work standards for practice, goal setting, and research efforts. Evaluation practices may include the following:

- using appropriate tools such as clinical indicators, practice guidelines, consumer satisfaction surveys and measures, and standardized performance assessments
- assessing both outcome and process objectives
- involving the client and client system and colleagues in the evaluation process
- protecting the privacy of the client and client system and other professionals
- disseminating evaluative data to clients, payers, and other professionals on request and adhering to privacy rights
- using external practice evaluators as appropriate
- participating in social work research.

Standard 16. Access to Information and Technology

Health care social workers shall have access to computer technology and the Internet, as the need to communicate electronically and to seek information on the Web for purposes of education, networking, and resources is essential for efficient and productive practice.

Interpretation

Health care professionals, including social workers, communicate, learn, educate, and document using computer technology on a daily basis. Social workers need initial and ongoing training in technology applications relevant to their practice, including clinical care, research, policy, education, resource finding, and administration. Social workers

shall continue to follow guidelines for privacy with regard to confidential information of the client, family, or health care providers.

Standards for Professional Development, Education, and Leadership

Standard 17. Qualifications
Health care social workers shall meet the provisions set for practice by NASW. A sufficient number of qualified social work personnel shall be on staff to plan, provide, and evaluate social work services.

Interpretation
Health care social workers shall have a social work degree from a school accredited by the Council on Social Work Education (CSWE). As a distinct specialty within the social work profession, health care social work requires specialized knowledge as outlined in these Standards. The social worker should receive this knowledge and skill set from involvement or internship in a health care setting, preferably under social work supervision.

Social workers functioning in leadership roles, such as managers or directors, should be licensed at the advanced practice level and able to provide supervision for licensure. Their experience shall show evidence of advanced practice skills and judgment demonstrating progressively more professional competence and supervisory and management skills.

Standard 18. Continuing Education
Health care social workers shall assume responsibility for their own continued

professional development in accordance with the *NASW Standards for Continuing Professional Education* (NASW, 2002) and state requirements.

Interpretation

Social workers shall remain knowledgeable about medical diagnoses and advancements, and the psychosocial implications of illness, injury, disability, and treatment. To accomplish this goal, social workers shall continually seek to improve their practice through education and training, and to share this knowledge with other colleagues. Opportunities for professional education are available through health care organizations; NASW Web courses and chapters; participation and contribution to professional conferences, training events, and other activities; ongoing psychosocial research; current practice models; and professional publications.

Social workers shall assist in identifying health care and psychosocial topics for professional development by participating in research; by encouraging organizations and institutions to collaborate, advocate, and provide appropriate education for the field; and from clinical practice.

Standard 19. Supervision

A social work leader or supervisor shall be available to supervise health care social work staff on their responsibilities in practice, research, policy, orientation, and education.

Interpretation

The purpose of supervision is to enhance the clinical social worker's professional skills and

knowledge, to enhance competence in providing quality patient care. Supervision aids in professional growth and development and improves clinical outcomes. Experienced social workers shall offer guidance and consultation to students, interns, and less experienced peers. Consultation and guidance are separate from supervision, and may be offered in mentoring opportunities.

Standard 20. Leadership

Social workers across all health care settings have a responsibility to provide leadership to ensure access to care and to improve and maintain the quality of care provided by an agency or institution. Leadership skills can be demonstrated in teams and groups across health care settings, and include mentoring others within and outside the social work profession.

Interpretation

Social work leaders typically demonstrate knowledge, skills, and abilities in the following areas:

- management/administration, which includes supervision, consultation, negotiation and monitoring
- specialized knowledge of how to function within care teams in which various disciplines are involved
- research and education
- legal, ethical, and professional standards applicable to health social work practice including standards of documentation (paper and computer) and quality improvement activities

- ability to prioritize needs for social work services and to recommend adjustments to staffing levels accordingly based on current literature and industry standards
- social work qualifications, productivity, and continuing education
- policies and regulations that affect social work practice, and patient and family care
- information on access to health care for the underserved and marginalized populations
- consultation to social workers and allied health professionals on relative health social work practice issues
- development of and adherence to organizational policies, procedures, and regulations by staff.

Free information on the Standards is located on the NASW Web site: www.socialworkers.org.

Purchase full document from NASW Press at 1.800.227.3590.

References

Barker, R. L. (2003). *The social work dictionary* (4th ed.). Washington, DC: NASW Press.

Centers for Medicare and Medicaid Services. (2004a). Medicare information resource. [Online]. Retrieved from http://www.cms.hhs.gov/medicare/ on April 15, 2005.

Centers for Medicare and Medicaid Services. (2004b). Welcome to Medicaid. [Online]. Retrieved from http://www.cms.hhs.gov/medicaid/ on April 15, 2005.

Gilbert, J. (Ed.). (2003). *Principles and recommended standards for cultural competence education of health care professionals.* Los Angeles: California Endowment.

National Association of Social Workers. (1987). *NASW standards for social work practice in health care settings.* Washington, DC: Author.

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers.* Washington, DC: Author.

National Association of Social Workers. (2002). *NASW standards for continuing professional education.* Washington, DC: Author.

National Association of Social Workers. (2001). *NASW standards for cultural competence in social work practice.* Washington, DC: Author.

National Association of Social Workers. (2004). *NASW standards for social work practice in palliative and end of life care.* Washington, DC: Author.

Saleebey, D. (2003). Strengths-based practice. In R.A.English (Ed.in Chief) *Encyclopedia of social work* (19th ed. 2003 supplement, pp. 150-162). Washington, DC: NASW Press.

Tomaszewski, E. P. (Ed.). (2004).*The role of social work in medication treatment adherence.* Washington, DC: National Association of Social Workers, HIV/AIDS Spectrum Project.

U.S. Census Bureau. (2004) *Health insurance coverage: 2003/highlights*. Retrieved April 15, 2005, from http://www.census.gov/hhes/www/hlthins/hlthin03/hlth03asc.html

Acknowledgements

NASW would like to acknowledge the work of the Health Standards Workgroup for their contributions to the *NASW Standards of Social Work Practice in Health Care Settings*. The workgroup was comprised of social workers experienced in all facets of health care. The following individuals comprised the workgroup:

Nancy Campbell, MSW, LISW
Chief of Social Work Services
Cincinnati VA Medical Center

Nancy F. Cincotta, MSW
Mount Sinai Medical Center
New York, New York

Lisa E. Cox, PhD, LCSW, MSW
Associate Professor
The Richard Stockton College of New Jersey

Stuart Kaufer, ACSW, LMSW
Regional Resource Development Specialist
Center for Independence of Disabled of NY

Carol P. Marcusen, MSW, LCSW, BCD
Director of Social Services, Case Management, Patient Education
USC/Norris Cancer Hospital

Shirley Otis-Green, MSW, ACSW, LCSW
Senior Research Specialist
Nursing Research and Education Department
City of Hope National Medical Center

EXHIBIT

"5"

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Contents

- Introduction
- Scope of Practice for Social Work and Psychosocial Services
- **Recommended Core Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital**
  Appropriateness of Care Indicators
  - Indicator 1. Case Finding and Access
  - Indicator 2. Discharge Delays
- *Quality of Care Indicators (Process)*
  - Indicator 3. Patient and Family Involvement in Planning
  - Indicator 4. Timeliness
  - Indicator 5. Teamwork
- *Quality of Care Indicator (Outcome)*
  - Indicator 6. Readmissions with Social Complications
- **Recommended Additional Indicators**
  Quality of Care Indicator (Process)
  - Indicator 1. Follow-up
- *Quality of Care Indicator (Outcome)*
  - Indicator 2. Problem Resolution

Introduction

Monitoring the quality and appropriateness of psychosocial and social work services in acute care medical hospitals is an area of increasing concern to the health care field. Social workers and their supervisors desire specific measures of service delivery and patient care outcome to monitor quality and to position the profession strategically as the health care system evolves. Institutions and insurers call for quality services to avoid expensive delays in discharge and to prevent the need for readmissions. Accrediting organizations seek consistency in data collection, analysis, and comparison across institutions.

In response to these concerns, the National Association of Social Workers' Commission on Health and Mental Health, in conjunction with the Society of Hospital Social Work Directors of the American Hospital Association, has established clinical indicators to be used in the systematic monitoring of the quality and appropriateness of patient care. Indicator development is an ongoing process that encompasses testing, improvement, and innovation. These indicators serve as broad guidelines to allow for the varied needs of diverse institutions while encouraging more uniformity in social work quality assurance.

Clinical indicators are not intended as direct measures of the quality of clinical performance. They are best thought of as "flags" that, at a predetermined threshold, "go up" and signal the need for problem analysis or peer review.

The following information is provided for each indicator:

1. Rationale: an explanation of the logical connection between the "flag," social work functions, and an important dimension of quality
2. Operational definition: a definition of the indicator that allows for reliable measurement across practice settings
3. Threshold: the predetermined point at which the "flaggoes up," precipitating closer scrutiny and evaluation
4. Data elements: the specific information needed to measure the indicator
5. Other influencing factors: factors beyond the control of the individual practitioner that influence the provision of care

Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital were developed by a panel of recognized expert practitioners from a variety of related settings and facilities and reviewed by practitioners in the field. NASW's Commission on Health and Mental Health and the Board of Directors of the Society of Hospital Social Work Directors formally accepted the indicators in June 1990.

Scope of Practice for Social Work and Psychosocial Services

Mission

Social work services are provided to patients and their families to meet their medically related social and emotional needs as they impinge on their medical condition, treatment, recovery, and safe transition from one care environment to another.

Patients Served

Depending on individual circumstances and need, social work services are available to all patients and their families. Groups at high psychosocial risk include frail elderly patients, chronically ill people, children and adults with handicapping conditions, victims of maltreatment, and critically ill patients. Social workers serve patients who are insured, uninsured, and underinsured.

Major Functions and Services Provided

- Psychosocial assessment
- High social risk case finding and screening
- Information and referral Preadmission planning
- Discharge planning Psychosocial counseling
- Financial counseling
- Health education
- Postdischarge follow-up
- Consultation
- Outpatient continuity of care
- Patient and family conferences
- Case management
- Self-help and emotional support groups for patients and families
- Patient and family advocacy

Major Categories of Problems Addressed

- Problems related to care and activities of daily living
- Environmental problems
- Patient and family adverse reactions or dysfunctional adjustment to illness and changes in functional status
- Problems related to physical, sexual, and emotional maltreatment
- Relationship problems
- Problems of behavior and cognition and mental disorders, including substance abuse
- Vocational and educational problems
- Legal problems

Providers

Social work services are performed by qualified social workers and others under the supervision or direction of the social work department.

Recommended Core Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Appropriateness of Care Indicators

Indicator 1

Important aspect of care. Case finding.

Rationale. Patients who need social work intervention must receive it for overall care to be considered appropriate. The percentage of inpatients needing social work in a hospital should remain similar over time unless there is a change in case mix, scope of services, or the surrounding environment. Thus, major shifts in the percentage of discharges receiving social work services may be a sign that the case finding mechanisms are not proper and that care may not be appropriate.

Operational definition. Rate of social work discharges to total discharges.

Threshold. Needs empirical determination.

Data elements. The number of cases discharged from the hospital by social work in one month divided by the total number of cases discharged by the hospital in that month.

Other influencing factors. Scope of service, case mix (social complexity), hospital type.

Indicator 2

Important aspect of care. Discharge planning.

Rationale. One aspect of appropriateness is that the amount of care received is not excessive. Excessive care results when discharge is delayed and patients remain at higher levels of care than are medically necessary.

Operational definition. The percentage of patients designated as below acute level of care by utilization review (UR).

Threshold. Needs empirical determination.

Data elements. Number of patients staying beyond UR acute level of care divided by the number of discharges in one month.

Other influencing factors. Patient recertified.

Quality of Care Indicators (Process)

Indicator 3

Important aspect of care. Discharge planning.

Rationale. The standard of practice is that social workers must involve patients and their families in making their own decisions about posthospital care. Involvement must include, at a minimum, discussion of patient and family preferences.

Operational definition. Patient and family preferences are recorded in the social work discharge plan.

Threshold. 95 percent.

Data elements. The number of cases with patient and family preferences recorded in social work discharge plan divided by the number of social work discharges with social work discharge plan.

Other influencing factors. Incompetent patient, no family members available.

Indicator 4

Important aspect of care. All.

Rationale. Patients and families need sufficient time to make decisions and adapt to illness, and shortened lengths of hospital stay limit the availability of time. Therefore, the standard of practice is that most patients in need of social work services must receive their initial service early in their hospital stay.

Operational definition. The percentage of patients receiving their first social work service in the first quartile of their length of stay (in most cases, in the first 48 hours).

Threshold. Needs empirical determination.

Data elements. Date of admission, date of discharge, date of first social work contact after admission.

Other influencing factors. Patient stay is less than three days.

Indicator 5

Important aspect of care. Coordination of discharge planning.

Rationale. Social workers are responsible for coordination of patients' discharge plans, especially when posthospital care is required. When discharge of a patient receiving social work services occurs without the social worker's knowledge, this may indicate poor quality of the coordination process.

Operational definition. Social work patients discharged without social worker's knowledge.

Threshold. 0 percent.

Data elements. Number of social work patients discharged without social worker's knowledge divided by the number of social work discharges.

Other influencing factors. Service is information and referral only, consultation only, or psychosocial assessment only.

Quality of Care Indicator (Outcome)

Indicator 6

Important aspect of care. All.

Rationale. Social workers are responsible for ensuring that patients receive the immediate posthospital care they need and adapt to the posthospital setting. Readmission of too many patients due to social complications suggests either that they did not receive social work services or that these services were inadequate.

Operational definition. Percentage of discharges readmitted within 15 days with social complications or problems with posthospital care.

Threshold. Needs empirical determination.

Data elements. Number of patients readmitted with social complications divided by the number of hospital discharges.

Other influencing factors. Complications occurring after the primary discharge, case mix.

Recommended Additional Indicators

These indicators are highly desirable for use and provide direction for future quality assurance efforts. It is recognized that barriers in some hospitals may preclude their immediate implementation.

Quality of Care Indicator (Process)

Indicator 1

Important aspect of care. Discharge planning and follow-up.

Rationale. Patients who are at high risk for developing problems with postdischarge care should receive a follow-up assessment after discharge to determine whether the aftercare plan is being implemented as planned.

Operational definition. Percentage of discharged patients who received social work discharge planning who receive postdischarge follow-up within seven days.

Threshold. 95 percent.

Data elements. Number of discharged patients receiving social work postdischarge follow-up within seven days divided by the number of discharged patients receiving social work discharge planning.

Other influencing factors. Patient dies, case mix (social complexity).

Quality of Care Indicator (Outcome)

Indicator 2

Important aspect of care. All.

Rationale. The intent of social work intervention is to improve or resolve patients' psychosocial problems related to their medical care. Problem improvement or resolution is an indicator of whether the intervention has achieved its goal.

Operational definition. Percentage of planned results not achieved specific to each problem.

Threshold. Needs empirical determination.

Data elements. Number of social work patients discharged from hospital in one month having problem X with "not resolved" as outcome divided by the number of social work patients discharged from hospital in that month having problem X. This indicator requires a well-defined problem list and reliable categories for problem resolution.

Other influencing factors. Patient dies, case mix (social complexity).

Clinical Indicators Medical Hospital Work Group

- Barbara Berkman, DSW, Boston, Massachusetts
- Claudia Coulton, PhD, ACSW, Cleveland, Ohio
- Susan Haikalis, MSW, San Francisco, California
- Karen Kaplan, PhD, ACSW, Silver Spring, Maryland
- Shirley M. Keller, ACSW/ LISW, Akron, Ohio
- Helen Rehr, DSW, New York, New York
- Peggy A. Weil, ACSW, MPA, Silver Spring, Maryland
- Betsy Vourlekis, PhD, Catonsville, Maryland

NASW Commission on Health and Mental Health

- Allyson Ashley, ACSW, Springfield, Missouri
- Marvin A. Johnson, MSW, Palatine, Illinois
- Gracie Mebane Vines, MSSW, ACSW, Greenville, North Carolina

- Terry Mizrahi, PhD, New York, New York
- James M. Karls, DSW, ACSW, Sausalito, California
- Juan Ramos, MSW, ACSW, Rockville, Maryland
- Della Wills, MSW, ACSW, QCSW, Homer, Louisiana

Top of Page Email this Link Print this page

National Association of Social Workers
750 First Street, NE • Suite 700 • Washington, DC 20002-4241
©2013 National Association of Social Workers. All Rights Reserved.

EXHIBIT

"6"

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Abuse
Number: PR 110.03
Date of Issue: 08/91 Reviewed / Revised: 05/11

JUVENILES SUSPECTED OF BEING ABUSED OR NEGLECTED

SUMMARY STATEMENT

This policy statement relates to the issue of awareness, detections and management of children at risk for abuse or neglect in the inpatient, physician office, and urgent care settings. It provides guidance on the procedure that should be followed in cases of suspected abuse or neglect.

DEFINITIONS

A. **Juvenile**

Any person under 18 years of age who is not emancipated by marriage or court order, or a member of the armed forces.

B. **Abused Juvenile**

1. A juvenile whose parent, guardian, custodian or caretaker

   a. inflicts or allows to be inflicted serious physical injury, which causes or creates a substantial risk of injury, death, disfigurement, impairment of physical health or loss or impairment of a function of any bodily organ;

   b. uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;

   c. creates or allows serious emotional damage;

   d. commits or permits illegal sexual activity with or by the juvenile; or

   e. encourages or approves the juvenile's commission of delinquent acts.

C. **Neglected Juvenile**

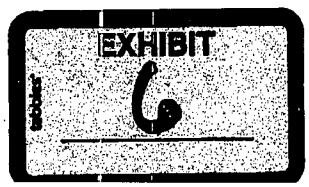
1. A juvenile who:

   a. is receiving improper care, supervision, or discipline;

   b. has been abandoned; (See abandoned infant/child policy)

   c. is not provided necessary medical or remedial care;

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002636



d. lives in an injurious environment or has been placed illegally in care or for adoption.

2. A special needs infant who:

   a. is being denied appropriate nutrition, hydration, or medication; or

   b. has medically indicated treatment withheld unless, in the treating physician's judgement, one of several conditions is met.

It is relevant to consider whether the juvenile lives in a home where another juvenile has died as a result of abuse or neglect or in a home where another juvenile has been subjected to physical abuse by an adult who regularly lives in the home.

D. **Dependent Juvenile**

1. A juvenile who:

   a. is in need of assistance or placement because there is no parent, guardian or custodian responsible for the juvenile's care or supervision; or

   b. has a parent, guardian, or custodian, due to physical or mental incapacity and in the absence of an appropriate alternative child care arrangement, who is unable to provide for care or supervision.

E. **Caretaker**

1. Any person other than a parent, guardian or custodian, or adult member of the juvenile's home, who has care of a juvenile, including any blood relative, stepparent, foster parent, or house parent, cottage parent, or other person supervising a juvenile in a residential child care facility; or

2. Any adult person with the approval of the care provider in a day care facility.

PROCEDURE

A.

1. Clinical team identifies child in whom abuse or neglect is suspected and initiates suspected child maltreatment inpatient order set followed by discharge order set if applicable.

2. Consult CHS Clinical Care Management Social Worker to aid in the assessment process.

   CPN/Urgent Cares: page 704-355-4088 pager 1436.

   CHS Hospitals: utilize your hospital MSWs during regular business hours (8:00am - 4:30pm) and page 704-355-4088 pager 1436 for after hour concerns. Refer to NC Statute 90-21.20 (b) for indications for law enforcement involvement (Attachment A).

3. Complete CHS Suspected Child Abuse and Neglect (SCAN) form available on Care

Line. Use SCAN admission and discharge order forms for admission to LCH.

4. Document all positive exam findings on SCAN form including completion of diagrams. If evidentiary photography is requested by outside agency they are responsible for securing such photography and maintaining chain of custody. Contact SCAN on call team or Child Maltreatment Coordinator for assistance with photography documentation needed for child's medical management.

5. All cases of suspected abuse or neglect should be reported to the Department of Social Services (DSS) in the County where the child resides. The call to DSS may be initiated by the staff member identifying the abuse/neglect, the medical social worker or any other member of the healthcare team involved in the case. Have readily available as much of the following information as possible:

   - the facts of the case
   - the child's and parents' home address, telephone numbers, dates of birth and social security numbers
   - siblings names, ages and whereabouts

6. If the parent, guardian, custodian or caretaker refuses to authorize necessary medical treatment for the juvenile, refer to administrative policy *PR 120.06 Consent for Treatment.*

7. Consider consult to CMC Pediatrics (CHIPS Team; Children's Hospital Inpatient Service) for assistance with medical management. For patients with evidence of acute, multi-system injury consult CMC Trauma Service.

8. Refer to Child Maltreatment Clinical Practice Guidelines to assist with medical management. (Attachment B, B1-3)

9. **When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS and the safety plan has been placed on the chart in writing, if applicable.**

B. When a physician determines that a juvenile should remain in the hospital for medical reasons, or that it is unsafe for the juvenile to return to his or her parent, guardian, or caretaker, the physician or administrator should first contact the director of the Department of Social Services (or representative on call) to determine if the Department of Social Services will take emergency custody and authorize the hospital to retain physical custody of the juvenile.

   In the event the Department of Social Services is unwilling to take custody or cannot be contacted, the local District Court has authorized the physician or administrator to retain physical custody of the juvenile whenever the physician determines that (1) the juvenile should remain for medical treatment or (2) according to his or her medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker. (See *Administrative Order, Attachment C)*

To retain physical custody under court order, the physician who examines the juvenile must certify the applicable circumstances in writing on the *Certification of Necessity for Retention of Custody, Attachment D.* A copy of the written certification must be provided to the juvenile's parent, guardian, custodian, or caretaker and the director of the Department of Social Services. A copy of the completed certification must be placed in the juvenile's medical record.

The Administrative Order allows the hospital to keep physical custody of the juvenile for a period not to exceed twelve hours from the time and date of the written certification. Before the twelve hours expire, either the Department of Social Services must have assumed custody or the Juvenile Court must issue an additional order permitting continued custody beyond twelve hours.

C. Any person making a report of suspected juvenile abuse, neglect, or dependency, or who testifies in a later court proceeding resulting from a report, is immune from civil or criminal liability so long as the person acted in good faith.

D. If it is suspected the juvenile has been the victim of a crime but does not come under the definition of "abused juvenile" or "neglected juvenile", the juvenile's parent, guardian, custodian, or caretaker and/or law enforcement officials should be notified. **If a juvenile seeks treatment for a sexually related assault then reporting is based on the juvenile's consent (NC Statue 90-21.5).** See (Attachment E).

E. Any questions concerning this procedure should be directed to the facility administrator or the Carolinas HealthCare System office of Risk Management.

REFERENCES

See Attachment A: Involvement of Law Enforcement (NC Statute 90-21.20 (b)).
See Attachment B: Child Maltreatment Clinical Practice Guidelines
See Attachment C: Administrative Order Retention of Custody of Juvenile Suspected to be Abused
See Attachment D: Certification of Necessity for Retention of Custody
See Attachment E: Situations in which minors may consent to treatment (NC Statute 90-21.5)
See Attachment F: Child Abuse and Neglect Algorithm

APPROVALS

Policy Coordinator	Glenda Wooten, Assistant Vice President, Patient Care Services, LCH
Policy Approvers	Martha Whitecotton, Vice President, Administrator, LCH
	Suzanne Freeman, Senior Vice President, Carolinas HealthCare System
	Dennis Phillips, Executive Vice President, Metro Group

Attachment A
INVOLVEMENT OF LAW ENFORCEMENT

Article 1C

Physicians and Hospital Reports

§90-21.20. Reporting by physicians and hospitals of wounds, injuries and illnesses.

(a) Such cases of wounds, injuries or illnesses as are enumerated in subsection shall be reported as soon as it becomes practicable before, during or after completion of treatment of a person suffering such wounds, injuries, or illnesses. If such case is treated in a hospital, sanitarium or other medical institution or facility, such report shall be made by the Director, Administrator, or other person designated by the director or Administrator, or if such case is treated elsewhere, such report shall be made by the physician or surgeon treating the case, to the chief of police or the police authorities of the city or town of this State in which the hospital or other institution, or place of treatment is located. If such hospital or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above the sheriff of the respective county or to the one of his deputies.

(b) Cases of wounds, injuries or illnesses which shall be reported by physicians, and hospitals include every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm, every case of illness apparently caused by poisoning, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician or surgeon treating the case that a criminal act was involved, and every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician or surgeon treating the case that the wound, injury, or illness resulted from a criminal act of violence.

(c) Each report made pursuant to subsections (a) and (b) above shall state the name of the wounded, ill or injured person, if known, and the age, sex, race, residence or present location, if known, and the character and extent of his injuries.

(c1) In addition to the reporting requirements of subsection (b) of this section, cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma shall be reported by the physician as soon as it becomes practicable before, during, or after completion of treatment. If the case is treated in a hospital, sanitarium, or other medical institution or facility, the report shall be made by the Director, Administrator, or other person designated by the Director or Administrator of the medical institution or facility, or if the case is treated elsewhere, the report shall be made by the physician or surgeon treating the case to the chief of police or the police authorities of the city or town in this State in which the hospital or other institution or place of treatment is located. If the hospital

or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above to the sheriff of the respective county or to one of the sheriff's deputies. This reporting requirement is in addition to the duty set forth in G.S. 7B-301 to report child abuse, neglect, dependence, or the death of any juvenile as the result of maltreatment to the director of the department of social services in the county where the juvenile resides or is found.

(d) Any hospital, sanitarium, or other like institution or Director, Administrator, or other designated person, or physician or surgeon participating in good faith in the making of a report pursuant to this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as the result of the making of such report. (1971, c.4; 1977, c. 31; c. 843, s.2.)

Attachment B
CHILD MALTREATMENT CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines
CHS Inpatient Units and Emergency Department

Evaluation and Management of Suspected Child Abuse or Neglect

I. CHILD PHYSICAL ABUSE

A. Identification

Injuries (bruises, burns, fractures; this list is not inclusive) that should be considered suspicious for physical abuse:

1. Age 0-6 months: Any injury.

2. Age 6 months or older:

   a. Bruises, lacerations, or burns to protected, fleshy, or flexor surfaces— for example, inner thighs, abdomen, neck, face (other than frontal prominence), pinna, and genitalia.
   b. Bruises, lacerations, or burns showing an object pattern—for example, belt loop, cigarette burn, and curling iron.
   c. Full thickness burns, especially scald burns.
   d. Fractures, especially metaphyseal fractures, complex or wide skull fractures, rib fractures, sternal fractures, spinous process fractures or scapula fractures.
   e. Significant head injury, especially subdural hematoma, retinal hemorrhage, subgaleal hematoma, avulsed hair, complex or wide skull fracture. Head injury should be considered whenever a child presents with vomiting or altered consciousness, or bloody spinal fluid is found on lumbar puncture, but an infectious process cannot be readily diagnosed.
   f. Intraabdominal injury, especially rupture or hematoma of internal organ.

3. Age 0-10 years (or older based on clinical evaluation): Positive urine or blood screen for alcohol or drugs of abuse. Injuries that are not consistent with history.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian or child give a logical explanation that is consistent with the age, pattern, and severity of the injury? This should be assessed by clinician familiar with normal pediatric development.

   a. Consider developmental level of child. Is the child capable of the reported action? For example—a 6-month-old cannot unbuckle a car seat.

b. Consider biomechanics of injury. For example--a fall from less than 4 feet rarely causes a fracture and almost never causes intracranial hemorrhage; a child who cannot crawl or walk should not have a bruise, fracture, burn, or laceration.

C. Evaluation & Treatment

1. Refer to CHS policy *PR 110.03* for policies regarding reporting of *Juveniles Suspected of Being Abused or Neglected.*

2. Complete physical examination

3. Complete SCAN form (available on Care Line) and SCAN Admission Order Set.

4. Age 0-2 years: Non-accidental Trauma (NAT) series should be considered in all cases (not long bone series or "babygram"). **Pediatric radiologist to do official reading.**

5. Age 2-4 years: NAT series should be considered (not long bone series or "babygram"). **Pediatric radiologist to do official reading.**

6. Nuclear medicine bone scan (or repeat NAT series in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial NAT series (for example-- in cases of Abusive Head Trauma (formerly known as "Shaken Baby Syndrome").

7. A screening panel to rule-out bleeding disorder should be considered (refer to SCAN Admission Order set).
   a. CBC with platelets & peripheral smear
   b. PT/PTT
   c. PFA-100 (platelet function assay)
   d. Fibrinogen
   e. Thrombin time

8. Liver enzymes (AST/ALT), amylase, and lipase levels should be considered if abdominal trauma is suspected or present.

9. CT scan of head if suspected acute intracranial injury or other injuries that indicate need to assess for non-accidental injuries; consider MRI scan of head if subacute (older than 5 to 7 days) or chronic intracranial injury after 2-3 days and patient is stable.

10. CT scan of abdomen if suspected blunt thoracoabdominal trauma or abdominal bruising present.

11. Pediatric Ophthalmology consult for thorough fundoscopy in cases of:
    a. Suspected intracranial injury;
    b. Suspected Abusive Head Trauma (metaphyseal fractures, subdural/subarachnoid

hemorrhage, and/or posterior rib fractures).

c. Spiral fracture, metaphyseal fracture, or other injury in child under age 2 suggestive of shaking or twisting injury.

d. Fracture in infant under age 6 months or any other highly specific fracture for abuse under 1 year.

II. CHILD SEXUAL ABUSE

A. Identification

Findings that should be considered suspicious for sexual abuse (this list is not inclusive):

1. Any injury to the genitalia (especially to the hymen or vestibule in girls) or anus.

2. Identification of an STD: Chlamydia, gonorrhea, HSV, HPV, HIV, HBV, HCV, Trichomonas, syphilis.

3. Positive pregnancy test (especially if < 14 y/o).

4. Any history or statement or witnessed incident consistent with sexual abuse.

B. Essential Aspects - Caretaker History

1. Does the parent/guardian or child give a logical explanation that is consistent with the examination findings? For example--in a child under 3 with genital warts, is there a history of maternal HPV infection during pregnancy or delivery?

C. Evaluation & Treatment

1. Refer to CHS policy *PR 110.03 Juveniles Suspected of Being Abused or Neglected* for policies regarding reporting.

2. Complete physical examination

3. Use SCAN form for documentation.

4. Age 0-2 years: skeletal survey in all cases with visible acute injuries.

5. Age 2-4 years: skeletal survey should be considered if visible acute injuries.

6. For non-acute sexual abuse allegations in an otherwise healthy child without continued access to an alleged perpetrator: after reporting to the appropriate investigating agencies, a child may be referred to their primary care provider or Pat's Place Child Advocacy Center in lieu of receiving a detailed sexual abuse examination in the Emergency Department.

7. Careful inspection of external genitalia and anus for evidence of trauma, in exam

setting with adequate lighting, positioning, and magnification. Never force a child to be examined.

a. Position child in a supine frog-leg position; adolescent male in supine position for genitalia and decubitus position for anus exam; adolescent female supine in heelrests (dorsal lithotomy).
b. In girls, use gentle labial traction technique to visualize vestibule and hymen. Also inspect labia majora, perineum, inner thighs, and lower abdomen.
c. In girls, position in the prone knee-chest position to confirm suspected abnormal hymenal or vestibular findings.
d. In boys, careful inspection of penis, scrotum, perineum, inner thighs, lower abdomen.
e. In both sexes, careful inspection of anus and perianal area for evidence of trauma. Use gentle gluteal separation to inspect anal rugae and outer canal.

8. Testing for sexually transmitted infection may be obtained if the history suggests the child had genital/anal/oral contact with the perpetrator's genitalia, there is evidence of genital/anal/oral trauma, or if there is genital/anal discharge:

- Gonorrhea cultures (Thayer Martin media, NOT DNA PROBES) of: throat; vagina (in prepubertal or young teen girls), cervix (in postpubertal girls), or male urethra, and anus.
- May consider use of urine PCR (urine NAAT) testing for Gonorrhea or Chlamydia, but is not considered legal gold standard. Positive urine PCR should be confirmed with culture. Obtain culture if giving prophylaxis in prepubertal patients
- Chlamydia cultures (pink viral culture media, NOT DNA PROBES) of: vagina (in prepubertal or young teen girls), cervix (in postpubertal girls) or male urethra, and anus.
  Note: to cause minimal discomfort while culturing the vagina in prepubertal girls, the examiner should use labial traction technique to identify the hymenal introitus. An assistant should gently insert a mini-tip (urethral-size) Dacron swab moistened with nonbacteriostatic saline or water through the introitus without contacting the hymen, and gently swab the distal vagina.
- Blood should be drawn for syphilis and HIV. Evaluate the patient's hepatitis B immunization status.
- Wet prep of discharge for trichomonas, clue cells, or leukorrhea (>10WBC/HPF).
- Culture of vesicles or ulcers for HSV.
- HIV and RPR should be obtained if indicated by history.

9. If acute sexual assault (penetrating genital injury and/or contact with perpetrator's genitalia within the past 72 hours):

a. A forensic evidence collection kit (SBI rape kit) should be utilized. Contact the relevant law enforcement agency for retrieval of evidence and maintain appropriate chain of custody.

b. Cultures and blood for STD's should generally not be obtained unless there is an additional clinical indication (prior abuse or symptoms).
c. DNA probes may be obtained (see above) as screening. However cultures remain the gold standard.
d. Prophylactic antibiotic therapy against gonorrhea and chlamydia infection should be given if requested by patient or family in case of child sexual assault. Consider prophylaxis against trichinosis and pregnancy. Prophylactic therapy should be administered in cases of adolescent sexual assault. Refer to Centers for Disease Control or American Academy of Pediatrics guidelines for current recommendations. See Attachment # B-1.
e. Prophylactic antiretroviral therapy should be offered to the victim and/or family whenever contact with potentially infectious bodily fluids may have occurred, and must be offered if the alleged perpetrator is known to be at high risk for HIV infection. If the perpetrator is unknown, the decision for therapy should be based on the local HIV epidemiological rate. Consultation with on-call pediatric infectious disease physician and SCAN on call physician is recommended. See Attachments # B-2.
f. Emergency contraception (Plan B) should be offered to all pubertal or postpubertal female victims. See Attachment # B-3.
g. Consult appropriate surgical subspecialist (Gynecology, Pediatric Surgery, or Pediatric Urology) in cases of severe anogenital injury.

10. Whenever possible, arrange medical follow-up according to the following schedule:

a. ~~In 1-2 days with PCP or Pat's Place Child Advocacy Center for further~~ examination and photodocumentation of injuries;
b. In 1 month, 3 months, and 6 months with PCP, or appropriate specialist or caregiver for follow-up examination and testing for STD's, especially HIV.

11. Discuss and assist with referral for psychological counseling through Victim's Assistance, community mental health resources, and/or family's medical health plan. Crisis counseling for child and family is often necessary.

III. CHILD NEGLECT

A. Identification

Growth parameters below expected for age.

1. Lack of medical care for a significant health problem—for example, no medications for asthma, diabetes; no care of severe dental caries.

2. Lack of normal bonding with parent/guardian.

3. Disregard of one or more basic child care needs—for example, not feeding infant/child, child found in street, failure to place child in auto safety seat or belt.

Note: A child may have findings suggesting more than one form of abuse or neglect.

B. **Essential Aspects - Caretaker History**

1. Does the parent/guardian give a reasonable explanation that is consistent with the pattern and severity of the findings suggesting neglect (and can he/she provide documentation)? For example—has a child who is small for age been worked up for medical or familial causes of short stature/failure to thrive?

C. **Evaluation & Treatment**

1. Age 0-2 years: skeletal survey should be considered.
2. Nuclear medicine bone scan (or repeat skeletal survey in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey.
3. MRI scan of head if there is a suspicion for subacute or chronic intracranial injury.
4. Complete physical examination, including inspection of genitalia and search for dysmorphic features.
5. Developmental assessment.
6. Laboratory evaluation: CBC, electrolytes, glucose, urinalysis, urine C&S. Other labs as indicated clinically (e.g., lead level).
7. Nutrition consult/assessment with caloric quantification if possible.
8. Other consults as indicated clinically.
9. Document child's caloric intake, weight gain, and response to hospital staff.
10. Document level of parental involvement and any concerns regarding inappropriate parental behaviors, attachment, statements, or level of knowledge regarding the child, his/her care, or his/her condition.

ATTACHMENTS:

B-1. Presumptive Treatment of STDs in Sexual Assault Victims
B-2. HIV Prophylaxis
B-3. Guidelines for Emergency Contraception

Attachment # B-1

Presumptive Treatment of STD's in Sexual Assault Victims (adapted from CDC Guidelines, 2006)

Children: The risk of a child acquiring an STD as a result of sexual abuse or assault has not been determined. Presumptive treatment for children who have been sexually assaulted or abused is not recommended because: a) the prevalence of most STDs is low following abuse/assault, b) pre-pubertal girls appear to be at lower risk for ascending infection than adolescent or adult women, and c) regular follow-up of children usually can be ensured. However, some children or their parent(s) or guardian(s) may be concerned about the possibility of infection with an STD, even if the risk is perceived to be low by the health-care provider. Such concerns may be an appropriate indication for presumptive treatment in some settings and may be considered after all specimens for diagnostic tests relevant to the investigation have been collected.

Adolescents: Many specialists recommend routine preventive therapy after a sexual assault because follow-up of survivors of sexual assault can be difficult and because these persons may be reassured if offered treatment or prophylaxis for possible infection. The following prophylactic regimen is suggested as preventive therapy.

- Postexposure hepatitis B vaccination, without HBIG, should adequately protect against HBV. Hepatitis B vaccine should be administered to sexual assault victims at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1--2 and 4--6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas, and BV may be administered.

Recommended Regimen:

Follow 206 CDC guidelines (refer to www.cdc.gov)

NOTE: For patients requiring alternative treatments, see the sections in this report that specifically address the appropriate agent. The efficacy of these regimens in preventing gonorrhea, trichomoniasis, BV, and *C. trachomatis* genitourinary infections after sexual assault has not been evaluated. Clinicians should counsel patients regarding the possible benefits, as well as the possible toxicity, associated with these treatment regimens; gastrointestinal side effects can occur with this combination. Providers may also consider anti-emetic medications if prophylaxis is administered, particularly if emergency contraception is also provided.

Other Management Considerations

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding the following:

- symptoms of STDs and the need for immediate examination if symptoms occur and abstinence from sexual intercourse until STD prophylactic treatment is completed.

Attachment # B-2

HIV prophylaxis *(Nonoccupational Postexposure Prophylaxis = nPEP)*[1]

HIV infection has been reported in children whose only known risk factor was sexual abuse. Serologic testing for HIV infection should be considered for abused children. The decision to test for HIV infection should be made on a case-by-case basis, depending on the likelihood of infection among assailant(s). Data are insufficient concerning the efficacy and safety of postexposure prophylaxis among both children and adults. However, antiretroviral treatment (*a 28-day course of highly active antiretroviral therapy –HAART)*, is well tolerated by infants and children with and without HIV infection; in addition, children who receive such treatment have a minimal risk for serious adverse reactions because of the short period of time recommended for prophylaxis.

In those cases in which a child presents to a health-care provider shortly after a sexual exposure (i.e., within 72 hours), the assailant(s) are likely to be at risk for HIV infection, and likelihood of compliance with treatment regimens is high, the potential benefit of treating a sexually abused child should be weighed against the risk for adverse reactions. **If antiretroviral postexposure prophylaxis is being considered, a professional specializing in HIV-infected children should be consulted.** If treatment is started, then medication should be given for the full 28 day course of therapy.

Recommendations for Postexposure Assessment of Children within 72 Hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in the assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in treating HIV-infected children if postexposure prophylaxis is considered.
- If the child appears to be at risk for HIV transmission from the assault, discuss postexposure prophylaxis with the caregiver(s), including its toxicity and its unknown efficacy.
- If caregivers choose for the child to receive antiretroviral postexposure prophylaxis, provide enough medication until the return visit at 3--7 days after initial assessment to reevaluate child and to assess tolerance of medication; dosages should not exceed those for adults.
- Perform HIV antibody test at original assessment, 6 weeks, 3 months, and 6 months.

Recommendations for Postexposure Assessment of Adolescent and Adult Survivors within 72 hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in HIV treatment if postexposure prophylaxis is considered.

- If the survivor appears to be at risk for HIV transmission from the assault, discuss antiretroviral prophylaxis, including toxicity and unknown efficacy.
- If the survivor chooses to receive antiretroviral postexposure prophylaxis, provide enough medication to last until the next return visit; reevaluate survivor 3--7 days after initial assessment and assess tolerance of medications.
- Perform HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

Assistance with postexposure prophylaxis decisions can be obtained by calling the National HIV Telephone Consultation Service (tel: 800-933-3413)

1. U.S. Department of Health and Human Services. Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. *MMWR*. January 21, 2005 / 54(RR02);1-20.

Attachment # B-3 Emergency Contraception

Plan B is an emergency contraceptive that can be used to prevent pregnancy following unprotected intercourse. Each Plan B packet includes a single course of treatment and consists of two tablets; each tablet contains 0.75 mg levonorgestrel.

To obtain optimal efficacy, the first tablet should be taken as soon as possible within 72 hours of intercourse. The second tablet must be taken 12 hours later.

Taken within 72 hours of unprotected intercourse, Plan B can, when used correctly, reduce the risk of pregnancy by 89 percent after a single act of unprotected sex. Effectiveness declines as the interval between intercourse and the start of treatment increases

When used as directed, Plan B is safe for most women. There have been no serious complications associated with Plan B. Common side effects include nausea, abdominal pain, fatigue, headache, and menstrual changes. Women who are pregnant, have undiagnosed vaginal bleeding, or have an allergy to the product should not use Plan B. Plan B cannot terminate an established pregnancy.

Use of Yuzpe Regimen using other oral contraceptives is acceptable Emergency Contraception if plan B is not available.

Patient should be advised to obtain pregnancy test if no vaginal bleeding in 28 days after completing Emergency Contraception.

NORTH CAROLINA AND SOUTH CAROLINA DSS AGENCIES

You must call the Department of Social Services in the county that the child is a permanent resident of. Numbers for each county are listed below.

COUNTY	PHONE	ADDRESS
Anson	(704) 694-9351 CPS Intake	118 N. Washington St Wadesboro, NC 28170
Burke	(828) 439-2003	700 East Parker Rd. Morganton, NC 28680
Cabarrus	(704) 920-1400	1303 S. Cannon Blvd. Kannapolis, NC 28083
Caldwell	(828) 426-8200	1966-H Morganton Blvd. SW Lenoir, NC 28645
Catawba	(828) 324-9111	3030 Eleventh Ave. Dr., S.E. Hickc NC
Chester	(803) 377-8131 ext. 0	115 Reedy Street Chester, SC 29706
Chesterfield	(843) 623-2147 ext. 1	201 N. Page Street Chesterfield, SC 29709
Gaston	(704) 862-7500 ext. 1	330 N. Marietta Street Gastonia, NC 28052
Iredell	(704) 873-5631	PO Box 1146 Statesville, NC 28687
Lancaster	(803) 286-6914	1837 Pageland Highway Human Services Complex Lancaster, SC 29721
Lincoln	(704) 732-0738	PO Box 130, Lincolnton, NC 28093
Mecklenburg	(704) 336-3150	Wallace H. Kuralt Centre, 301 Billingsley Rd. Charlotte, NC 28211
Richmond	(910) 997-8415	125 Caroline St., Rockingham, NC 28379
Rowan	(704) 638-3175	1236 West Innes Street, Salisbury, NC 28144
Stanly	(704) 982-6100	1000 North First Street, Suite 2, Albemarle, NC 28001
Union	(704) 296-4300	1212 West Roosevelt Blvd. Monroe, NC 28111
York	(803) 684-2315 Dial 0 and ask for CPS Intake	P O Box 261 York, SC 29745

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002652

North Carolina and South Carolina Law Enforcement Agencies

Anson County
Sheriff's Office
119 N Washington St
Wadesboro, North Carolina 28170
(704)694-4188

Burke County
Sheriff's Office
150 Government Dr
Morganton, North Carolina 28655
(828)438-5500

Cabarrus County
Sheriff's Office
25 Corban Ave SE
Concord, North Carolina 28025
(704) 920-3000

Caldwell County
Sheriff's Office
2351 Morgantown Blvd. SW
Lenoir, North Carolina 28645
(828) 758-2324

Catawba County
Sheriff's Office
100 B Southwest Blvd
Newton, North Carolina 28658
(828) 464-5241

Cleveland County
Sheriff's Office
100 Justice Place
Shelby, North Carolina 28150
(704)484-4888

Gaston County
Sheriff's Office
PO Box 1578
Gastonia, North Carolina 28054
(704)866-3160

Guilford County
Sheriff's Office
400 W Washington St
Greensboro, North Carolina 27401
(336) 641-3690

Iredell County
Sheriff's Office
PO Box 287
Statesville, North Carolina 28687
(704)878-3180

Lincoln County
Sheriff's Office
700 John Howell Memorial Dr.
Lincolnton, North Carolina 28092
(704)732-9050

Mecklenburg County
Sheriff's Office
700 E 4th St
Charlotte, North Carolina 28202
(704)336-2543

OR Charlotte Mecklenburg Police Department
704-353-1000 or 911

Richmond County
Sheriff's Office
#1 Court St
Rockingham, North Carolina 28379
(910)997-8283

Rockingham County
Sheriff's Office
1088 NC 65
Wentworth, North Carolina 27375
(336)634-3232

Rowan County
Sheriff's Office
232 N Main St
Salisbury, North Carolina 28144
(704)636-1011

Rutherford County
Sheriff's Office
198 N Washington St
Rutherfordton, North Carolina 28139

Union County
Sheriff's Office
3344 Presson Rd
Monroe, North Carolina 28112

Stanly County
Sheriff's Office
201 S. Second Street
Albemarle, North Carolina 28001
(704) 283-3844

Union County
Sheriff's Office
3344 Presson Road
Monroe, North Carolina 28607
(704) 283-3844

Watauga County
Sheriff's Office
330 Queen St
Boone, North Carolina 28607

South Carolina Agencies

Chester County
P.O. Box 727
Chester, SC 29706-0727
(803) 581-5131

Chesterfield County
Courthouse, 200 W. Main St
Chesterfield, SC 29709
(843) 623-2101

Lancaster County
P.O. Box 908
Lancaster, SC 29721-0908
(803) 283-4186

York County
1675-2A York Highway
York, SC 29745
(803) 628-3059

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002653

09-19-2002 11:23am From-DISTRICT COURT JUDGE 7043420181 T-XX P 002/003 F-XX

STATE OF NORTH CAROLINA — IN THE GENERAL COURT OF JUSTICE

COUNTY OF MECKLENBURG — DISTRICT COURT DIVISION

ADMINISTRATIVE ORDER

RETENTION OF CUSTODY OF JUVENILE SUSPECTED TO BE ABUSED PURSUANT TO NCGS §7B-308

BY _____

Pursuant to North Carolina General Statutes §7B-308, it is hereby ordered that Carolinas Medical Center, Presbyterian Hospital, Mercy Hospital, Mercy Hospital South, University Hospital and Presbyterian Matthews Hospital are authorized to retain custody of a juvenile (anyone under the age of 18) when the examining physician certifies in writing that the juvenile is suspected of being abused and: (a) that the juvenile should remain for medical treatment; or (b) that according to the juvenile's medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

Custody assumed by this authority may not exceed twelve hours from the time and date contained in the Examining Physician's Certification without an additional Court Order.

When this action is taken, the physician or administrator of the hospital shall immediately notify the parent, guardian, custodian or caretaker of the juvenile and the Director of the Department of Social Services or his designee.

The purpose of this order is to allow for the legal retention of custody in emergency cases long enough for the Department of Social Services to investigate the case and, if appropriate, seek a Court Order for custody in accordance with North Carolina law.

Examining physicians shall utilize the Examining Physician's Certification form on the reverse side of this page whenever a juvenile is retained under the authority of this Order.

A copy of the Examining Physician's Certification must be given to the juvenile's parent, guardian, custodian or caretaker; the Department of Social Services; and the Chief District Court Judge (700 E. 4th Street, Suite 3304, Charlotte, North Carolina 28202), for placement in the juvenile's judicial records.

A copy of this Administrative Order must also be given to the parent(s), guardian, custodian or caretaker.

Each hospital shall maintain a file containing copies of all Examining Physician's Certifications executed under the authority of this Order at that hospital.

This Order replaces the Letter of Authorization issued October 5, 1993, by then Chief District Court Judge James E. Lanning.

This the 18 day of October, 2000.

William G. Jones
Chief District Court Judge

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002854

EXAMINING PHYSICIAN'S CERTIFICATION

Name of Juvenile: _____ Date of Birth: _____

Address: _____

_____

Name of Parent, Guardian, Custodian or Caretaker: _____

_____

Address: _____

_____

The undersigned examining physician hereby certifies that there is good cause to suspect that this juvenile is abused, and:

☐ should remain in _____ (name of facility) for medical treatment;

OR

☐ it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

The basis for this determination is:

_____

_____

_____

Date: _____

Time: _____

_____
Examining Physician

The juvenile's parent, guardian, custodian or caretaker was given an executed copy of this certification at _____ a.m./p.m. on _____.
(date)

DSS was notified of the execution of this certificate at _____ a.m./p.m. on _____.
(date)

An executed copy of this certificate was mailed to the Chief District Court Judge at 700 E. 4th Street, Suite 3304, Charlotte, NC 28202 on _____.
(date)

Attachment D
PR 110.03, Juveniles Suspected of Being Abused or Neglected

CERTIFICATION OF NECESSITY FOR RETENTION OF CUSTODY

Name of Juvenile: _____ Age: _____

Address of Juvenile: _____

_____

Name of Parent, Guarding, or Custodian: _____

Address: _____

_____

The undersigned physician has examined this juvenile and that examination reveals the following injuries / illness.

_____

_____

_____

_____

Based on the foregoing and additional facts set out below, the undersigned physician hereby certifies that:

☐ This juvenile should remain in _____ (name of facility) for medical treatment.

☐ In my medical evaluation, it is unsafe for the juvenile to return to his parent, guardian, custodian, or caretaker.

Additional reasons (if any) for retention of custody:

_____

_____

_____

_____

Date: _____

Time: _____ Signature: _____

Carolinas HealthCare System

CERTIFICATION OF NECESSITY FOR RETENTION OF CUSTODY

ADDRESSOGRAPH PLATE

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002656

Attachment E

CHAPTER 90. MEDICINE AND ALLIED OCCUPATIONS
ARTICLE 1A. TREATMENT OF MINORS
PART 1. GENERAL PROVISIONS

Go to the North Carolina Code Archive Directory

N.C. Gen. Stat. § 90-21.5 (2010)

§ 90-21.5. Minor's consent sufficient for certain medical health services

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-223. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-223.

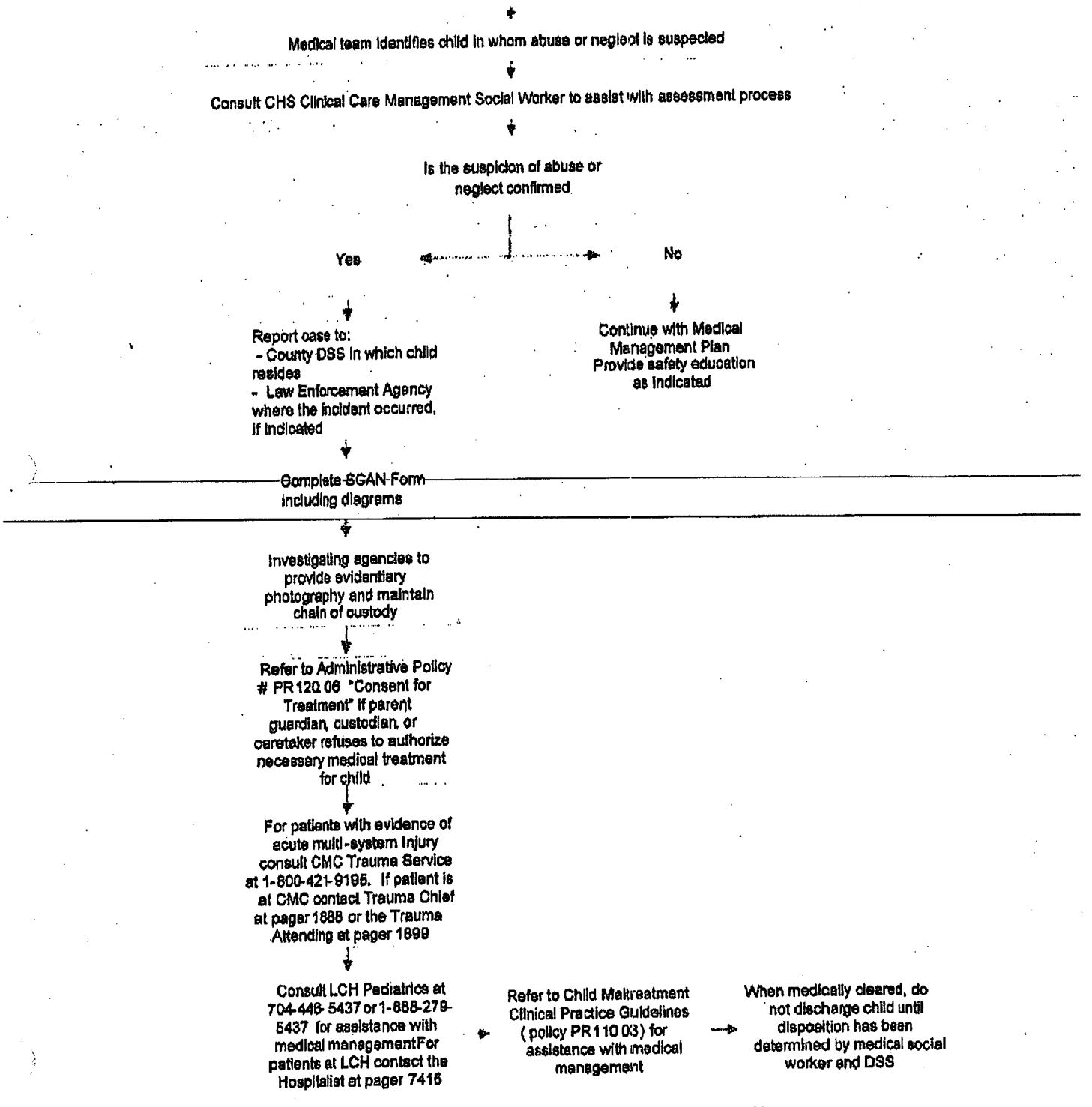
(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

HISTORY: 1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4; 2009-570, s. 10.

5273/1528
Rainey-Carduff v. Carolinas Med. Ctr.
002857

Attachment F

Child Abuse and Neglect Algorithm



EXHIBIT

"7"

Pediatrics
pediatrics.aappublications.org

Pediatrics Vol. 119 No. 6 June 1, 2007
pp. 1232 -1241
(doi: 10.1542/peds.2007-0883)

A statement of reaffirmation for this policy was published on 130 (2): e467.

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Evaluation of Suspected Child Physical Abuse

Nancy D. Kellogg, MD, and the Committee on Child Abuse and Neglect

ABSTRACT

This report provides guidance in the clinical approach to the evaluation of suspected physical abuse in children. The medical assessment is outlined with respect to obtaining a history, physical examination, and appropriate ancillary testing. The role of the physician may encompass reporting suspected abuse; assessing the consistency of the explanation, the child's developmental capabilities, and the characteristics of the injury or injuries; and coordination with other professionals to provide immediate and long-term treatment and follow-up for victims. Accurate and timely diagnosis of children who are suspected victims of abuse can ensure appropriate evaluation, investigation, and outcomes for these children and their families.

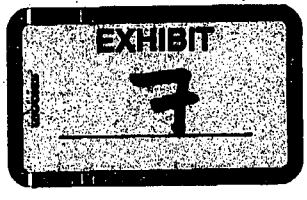
Key Words: physical abuse • child • child abuse • injury • evaluation

PREVALENCE

In 2004, 152250 children and adolescents were confirmed victims of physical abuse in the United States.[1] Of the 4 types of child maltreatment (neglect, physical abuse, sexual abuse, and emotional abuse), physical abuse is second to neglect, constituting approximately 18% of the total.[1]

Despite these statistics, the estimated number of victims is much higher; in 1 retrospective cohort study of 8613 adults, 20.4% reported they were pushed, grabbed, or slapped; had something thrown at them; or were hit so hard they got marks or bruises at some time during their childhood.[2] It has been estimated that 1.5% to 15% of childhood injuries that result in emergency department visits are caused by abuse.[3] Physical abuse remains an underreported (and often undetected) problem for several reasons including individual and community variations in what is considered "abuse," inadequate knowledge and training among professionals in the recognition of abusive injuries, unwillingness to report suspected abuse, and professional bias. For example, in 1 study,[4] 31% of children and infants with abusive head trauma were initially misdiagnosed. Misdiagnosed victims were more likely to be younger, white, have less severe symptoms, and live with both parents when compared with abused children who were not initially misdiagnosed. Such studies suggest a need for practitioners to be vigilant to the possibility of abuse when evaluating children who have atypical accidental injuries or obscure symptoms that are suggestive of traumatic etiologies but who do not have a history of trauma.

Child abuse has significant long-term medical and mental health morbidity.[5] Children with abusive head or abdominal injuries are more likely to die or become more severely incapacitated than are children with head or abdominal injuries caused by accidents.[6-8] Victims of physical abuse in childhood are more likely to develop a variety of behavioral and functional problems including conduct disorders, physically aggressive behaviors, poor academic performance, and decreased cognitive functioning.[9,10] Additional problems include anxiety and depression, as well as social and relationship deficits.



CHARACTERISTICS OF VICTIMS AND RISK FACTORS

Child physical abuse affects children of all ages, genders, ethnicities, and socioeconomic groups. Male and female children experience similar rates of physical abuse. In 1 survey study of more than 2000 children and adolescents,[11] 15% of adolescents received injuries from a physical assault and were more likely than children in younger age groups to receive injuries from abuse. Although the risk of physical abuse increases with age, fatal abuse and serious abusive injuries are more common among children and infants younger than 2 years.[1] Children in homes with annual incomes of less than $15000 per year have 3 times the number of fatalities, 7 times the number of serious inflicted injuries, and 5 times the number of moderate inflicted injuries when compared with children living in homes with annual incomes of greater than $15000 per year.[12] Risk factors for infant maltreatment include maternal smoking, the presence of more than 2 siblings, low infant birth weight, and an unmarried mother.[13] One study found that children living in households with unrelated adults were approximately 50 times more likely to die of inflicted injuries than were children residing with 2 biological parents.[14] The US Department of Health and Human Services has indicated that the rate of physical abuse is 2.1 times higher among children with disabilities than children without disabilities.[15] The presence of risk factors should not be used as indicators of child abuse but rather to provide guidance in prevention strategies as well as management and treatment plans.

ROLE OF THE PEDIATRICIAN

The role of the pediatrician encompasses prevention of abuse and detection and medical management of victims of abuse. Accurate identification of children who are suspected victims of abuse can facilitate appropriate evaluation, referral, investigation, and outcomes for these children and their families.[16] Children usually sustain abuse at the hands of a caregiver who misinterprets and responds inappropriately to the child's behavior. For example, caregivers who had smothered, shook, or slapped their infant within the first 6 months of life were more likely to be worried about crying and to believe that their infants cried excessively.[17] There is a close correlation between the age-specific incidence curve of infants hospitalized with abusive head trauma and the age-specific normal crying behavior of infants up to 36 weeks of age.[18]

In an anonymous telephone survey of 1435 mothers, 2.6% of children younger than 2 years were shaken by their mothers as a means of discipline.[19] Caregivers may respond inappropriately to their child's behavior when they are unduly stressed. Poverty, significant life events, and caregiver role conflicts are stressors that are often associated with abuse.[14] Pediatricians can effectively educate parents regarding the range of normal behaviors in infants and children, provide anticipatory guidance, and be a resource when the behavior becomes unmanageable for parents. In addition, pediatricians can screen for adult-partner violence; in 1 study, child abuse was 4.9 times more likely in families with identified spouse abuse than in families without identified spouse abuse.[20] Other conditions that place children at risk of being abused, such as maternal depression or drug abuse, may also be identified.

Careful medical assessment, detection of suspicious injuries, and reporting of abuse may prevent further abusive trauma in infants and adults.[4] In 1 study of abuse victims younger than 24 months, 73% had evidence of previous trauma or history of a previous injury.[21] Child abuse may recur 35% of the time without appropriate detection and intervention.[22]

As with other types of child maltreatment, there have been recent advances in medical knowledge regarding physical abuse. Most recent developments have addressed more accurate differentiation between inflicted and accidental injuries as well as detecting conditions that may mimic abusive injuries. Although consideration of nonabusive causes of injuries may merit additional evaluation and testing, the physician is mandated by law to report suspicions of abuse and should not delay reporting pending confirmatory testing or information. In all states, the law also provides some type of immunity for good-faith reporting. Once a suspected victim is identified and further assessment and management is required, using a pediatric child abuse consultant, if available, early in this process may obviate the need for invasive or expensive testing and can help direct the pediatrician toward appropriate evaluation. The

detection and diagnosis of child physical abuse depends on the clinician's ability to recognize suspicious injuries, conduct a careful and complete physical examination with judicious use of auxiliary tests, and consider whether the caregivers' explanation is supported by the characteristics of the injury or injuries and the child's developmental capabilities. The physician should also ensure that the child's immediate medical and safety needs are met. Child abuse injuries, particularly traumatic brain injuries, may result in significant long-term disabilities including learning deficits, attention-deficit/hyperactivity disorder, behavioral problems, seizures, spasticity, blindness, paralysis, and mental retardation.[23,24] Continuity of care for such children is essential, especially if they are transferred to other caregivers or foster homes.

Many hospitals and communities have developed child abuse-assessment teams of pediatricians and other professionals who specialize in the assessment of suspected victims of child abuse.[25] Such teams usually have access to additional information from law enforcement and child protective services, such as scene investigation, that may facilitate more thorough injury assessment and diagnosis. Involving such teams early in the process can ensure accurate and comprehensive assessments and information sharing among the medical and nonmedical disciplines involved and can provide for intermediate and long-term management of the child and family. Pediatricians with expertise in evaluating suspected abuse should provide training and assistance to emergency physicians and other first responders to enhance detection and appropriate referral of these patients.

Many regions do not have specialized child abuse teams but do have physicians with expertise in child abuse. Pediatricians should know which hospitals in their region have the most available expertise in the emergency evaluation of suspected child abuse. In turn, pediatricians with expertise in child abuse often act as consultants for emergency departments and child protective services. Close collaboration is necessary, particularly for establishing how the child should be transported between facilities, who should notify child protective services, who should notify the caregiver(s) of suspected abuse and when, and whether law enforcement should be notified. For those who do not require emergent transportation by ambulance, child protective services may facilitate transportation of a suspected child victim from one facility to another, assist in notifying the caregivers and law enforcement of suspected abuse, and provide an emergent safety plan on hospital discharge or clinic dismissal.

DEFINITIONS

The recognition and reporting of physical abuse is hindered by the lack of uniform or clear definitions. Many state statutes use words such as "risk of harm," "substantial harm," "substantial risk," or "reasonable discipline" without further clarification of these terms. Many states still permit the use of corporal punishment with an instrument in schools; on the other hand, the American Academy of Pediatrics has proposed that "striking a child with an object" is a type of physical punishment that "should never be used"[16] and has recommended that corporal punishment be abolished in schools.[17] The variability and disparities in definitions may hinder consistent reporting practices.

CLINICAL PRESENTATIONS AND SETTINGS

Most physical abuse injuries are likely to not be detected or reported. Minor injuries may not require medical attention and may be obscure or hidden. Infants and children are reported as suspected victims of physical abuse when 1 or more of the following occurs: an individual (including a professional) sees and reports a suspicious injury; an individual witnesses an abusive event; a caregiver observes symptoms and brings the child in for medical care but is unaware that the child has sustained an injury; an individual asks a child if he or she has been hurt in an abusive way; the abuser thinks the inflicted injury is severe enough to require medical attention; or the child victim discloses abuse. The American Academy of Pediatrics has indicated that "hospitalization of children requiring evaluation and treatment for abuse or neglect should be viewed by third-party payors as medically necessary."[26]

The clinical approach to an infant or child with possible abusive injuries is not significantly different from standard pediatric care. As with all patients, a severely injured child must be stabilized before further evaluation is

undertaken. This initial evaluation may encompass a trauma response team and pediatric specialists in surgery, emergency medicine, and critical care. Careful documentation may not be possible initially and must always be secondary to resuscitation and stabilization of the patient. Once the child is stabilized, a careful and well-documented history, as always, is the most critical element of the medical evaluation. Using quotes whenever possible, the pediatrician should document descriptions of the mechanisms of injury or injuries, onset and progression of symptoms, and the child's developmental capabilities. The physical examination should include detailed documentation, either by body diagrams and/or photographs, of any concerning cutaneous findings and should include a thorough search for other signs that may suggest a nontraumatic cause. If the child is verbal, it may be helpful to gather parental and patient histories separately. If abuse is a concern after this preliminary evaluation, consultation with a child abuse pediatrician, pediatric specialist, or pediatrician experienced in this area, if available, may be helpful in determining the best way to proceed with assessment.

Physical discipline is commonly inflicted on areas of the body that are concealed by clothing (eg, back/buttocks). When inflicted injuries are visible or incidentally discovered, child victims and their abusers typically explain the injuries as accidental; if clinicians or professionals are not critical or skeptical of this information, the injuries may be incorrectly attributed to accidental causes. Other victims present with severe inflicted injuries that require medical care. The initial history is typically vague and/or benign and may become inconsistent as the investigation progresses.

MEDICAL HISTORY

The interview of parents or caregivers of infants or children who present with serious injuries may be conducted in an outpatient or inpatient setting. If the child presents to a clinic with a serious injury that requires further medical care in a specialty (eg, orthopedics) or hospital setting, the clinician may opt to gather the minimum information to establish a need for reporting to child protective services. Any statements made by the caregiver regarding the injury should be documented accurately and completely. Once the clinician has assessed all the injuries, including approximate ages of injuries (when possible), a careful, complete, and detailed history should be obtained from the caregivers.

Explanations that are concerning for intentional trauma include:

1. no explanation or vague explanation for a significant injury;
2. an important detail of the explanation changes dramatically;
3. an explanation that is inconsistent with the pattern, age, or severity of the injury or injuries;
4. an explanation that is inconsistent with the child's physical and/or developmental capabilities; and
5. different witnesses provide markedly different explanations for the injury or injuries.

Information regarding the child's behavior before, during, and after the injury occurred, including feeding times and levels of responsiveness, should be gathered. Victims of significant trauma usually have observable changes in behavior. Access to caregivers and caregiver activities before, during, and after the injury occurred are also important to document. Frequently, infants and children present to medical settings with a history of a fall. Recent studies have indicated that short falls may result in bruising; however, more significant types of head trauma, including skull fractures, are exceedingly uncommon but possible.[18,19]

Information should be gathered in a nonaccusatory but detailed manner. Other information that may be useful in the medical assessment of suspected physical abuse includes:

1. past medical history (trauma, hospitalizations, congenital conditions, chronic illnesses);

2. family history (especially of bleeding, bone disorders, and metabolic or genetic disorders);
3. pregnancy history (wanted/unwanted, planned/unplanned, prenatal care, postnatal complications, postpartum depression, delivery in nonhospital settings);
4. familial patterns of discipline;
5. child temperament (easy to care for or fussy child);
6. history of past abuse to child, siblings, or parents;
7. developmental history of child (language, gross motor, fine motor, psychosocial milestones);
8. substance abuse by any caregivers or people living in the home;
9. social and financial stressors and resources; and
10. violent interactions among other family members.

PHYSICAL EXAMINATION

Most injuries of childhood are not the result of abuse or neglect. Minor injuries in children are exceedingly common. Physicians must also consider that unusual events, including accidents, do happen to children[31] and may produce injuries that are not characteristically seen from accidental causes. An injury pattern is rarely pathognomonic for abuse or accident without careful consideration of the explanation provided. In addition, both inflicted and accidental injuries may be seen simultaneously in a child.

General Assessment

The child's alertness and demeanor may reflect neurologic status and degree of discomfort and pain. A thorough and complete neurologic examination must be performed. For example, if alertness appears compromised, eye-opening, verbal, and motor responses should be assessed systematically. Spontaneous and symmetrical movement of all extremities should be noted, as well as any of the child's responses that indicate pain when extremities are examined and moved. Because abusive caregivers are rarely informative regarding the injuries that have been inflicted, special care should be taken during the examination of the child's extremities and neck, which may be fractured and require immobilization until diagnostic radiographs can be performed. Evidence of spinal cord injury, such as abnormal reflexes, muscle tone, or responsiveness to tactile stimuli, should be carefully pursued.

When the child is stable, height, weight, and fronto-occipital circumference should be carefully measured and then plotted on a growth chart. Previous measurements obtained from past medical visits should also be obtained to gauge whether growth velocity has been appropriate. Plotting parameters is essential, because clinicians may miss significant growth failure in infants and children if the clinician relies only on their clinical impressions. Physical abuse and failure to thrive are sometimes concurrent[32,33]; in addition, some children are starved intentionally.[34]

Evidence of neglect may be seen during the general examination of the infant or child; extensive dental caries, severe diaper dermatitis, or neglected wound care may be noted in addition to injuries that raise suspicion of abuse. Bald areas on the scalp may sometimes be seen with severe nutritional deficits or with traumatic alopecia. These findings should be differentiated from nonabusive or benign causes such as tinea capitis, alopecia areata, and occipital bald spots caused by supine positioning of young infants.

If the child can be interviewed, his or her demeanor should be noted during questioning. Some children display strong nonverbal cues of anxiety and reluctance when answering questions regarding potential abuse, because they are protective of their abuser or they fear retribution for "telling." Others may appear openly fearful of their abuser. Such responses may be important to consider when a safety plan for the child is made.

Skin Injuries

Location, size, and shape of any bruises, lacerations, burns, bites, or other skin injuries should be documented in a medical chart as well as with high-quality 35-mm or digital photographs. Inspection for injuries should be thorough and involve all aspects of the neck and head; mouth; extremities, including foot and hands; genitals; anus; buttocks; torso; and back. Obscure sites for inflicted injuries include the ears, especially the posterior aspects, the neck and angle of the jaw, scalp, and the frenula of the lip and tongue. In contrast to accidental injuries, inflicted injuries tend to occur on surfaces away from bony prominences, such as the neck, head, buttocks, trunk, hands, and upper arms.[36,38] In 1 patient series, approximately 60% of abused children had injuries on the head, face, or neck.[37] Hematomas of the scalp may be detected through palpation or may be visualized on radiographs. Some diaper bruises may not be readily visible for several hours; areas that are painful to palpate may require further examination in 1 to 2 days, when bruises may become apparent. Measurement of skin injuries may assist in determining the mechanism of injury and/or object used to inflict the injury. For example, a child that is kicked may have a discernable shoe imprint, or a knuckle imprint may be apparent if the child was punched.

Bite marks can yield important forensic information; referral to professionals that can gather such information and maintain a chain of custody is advisable.[38] Bite marks, recent or healed, should be carefully measured and photodocumented when possible; an intercanine distance of more than 2 cm suggests a human adult-sized bite.[39] In some facilities, forensic odontologists are available and may use special examination and photographic techniques to analyze bite marks. Fresh bites should be swabbed with sterile, premoistened cotton-tipped applicators for forensic analysis of potential genetic markers found in saliva.

The age of a bruise cannot be determined accurately.[40] Soft tissue swelling is seen more commonly with recent trauma but can persist for several days. The age and developmental capabilities of the infant or child also determine the frequency of bruising. For example, 1 study of infants and toddlers presenting for health maintenance examinations found that 17.8% of infants starting to "cruise" and 51.9% of ambulatory toddlers had bruises; bruises were observed only 2.2% of the time in infants who were not yet cruising.[35] In addition to accidents, bruising may occur secondary to coagulopathies and vasculitides such as idiopathic thrombocytopenic purpura, vitamin K deficiency, Henoch-Schönlein purpura, hemophilia, or von Willebrand disease.

Burn injuries may be chemical, thermal (including exposure to scalding liquids or hot objects), or electrical. The child's clothing worn during the burn should be collected and may provide information regarding the cause of the burn. Burns inflicted with hot objects can be difficult to differentiate from accidental mechanisms, because both burns may be patterned. The history, number of burns, and continuity of the burn pattern over curved body surfaces may indicate a greater probability of inflicted trauma. Accidental scalds most commonly involve hot liquids pulled or splashed onto the child's upper extremities, torso, and or neck and head.[41] Inflicted scalds or forced-immersion burns may be well demarcated in pattern, with few or no splash marks. When evaluating an apparent burn injury, other noninflicted causes to consider include chemical burns of the buttocks with senna-containing laxatives,[42] bullous impetigo, and accidents.

Cranial Injuries

Head trauma is the leading cause of child abuse fatalities.[43] When compared with child victims of severe accidents, children with abusive head trauma are more likely to have subdural and subarachnoid hematomas, multiple subdural hematomas of differing ages, more extensive retinal hemorrhages, and associated cutaneous, skeletal, and visceral injuries.[6] The inflicted injuries tend to occur in younger patients. Abusive head trauma tends to result in higher mortality and longer hospital stays than does accidental head trauma.[6,7] Infants with intracranial injuries frequently have no or nonspecific symptoms,[44,45] so the absence of neurologic symptoms should not exclude the need for imaging. Careful consideration of symptoms, signs, history, and judicious use of other ancillary tests should guide the clinician in determining the need for imaging.

Skull fractures can occur from accidents or inflicted injury. Studies have indicated that simple linear skull fractures can result from short falls of less than 3 ft and that such fractures are usually associated with scalp bruising or swelling.[46] However, it is unknown how many infants and children sustain skull

fractures from simple falls, are asymptomatic, and, therefore, never present for a medical evaluation; hence, the incidence of skull fractures among infants who sustain such falls is likely unknown. Abuse should be suspected when there is a history of minor head trauma such as a short fall in children with multiple, complex, diastatic, or occipital skull fractures.[47] Whenever an infant or child presents with a skull fracture, care should be taken to ensure that there are no other injuries.

Conditions that may be confused with abusive head trauma include glutaric aciduria type 1 (macrocranium, subdural hematoma, sparse intraretinal and preretinal hemorrhages, fronotemporal atrophy) and hemorrhagic disease of the newborn (including risk factors such as home birth, no vitamin K prophylaxis, or breastfeeding).

A fundoscopic examination for retinal hemorrhages should be considered for any infant or young child who is a suspected victim of physical abuse. Under optimal conditions, an ophthalmologist with pediatric experience should conduct an examination of dilated pupils by using indirect ophthalmoscopy. The ophthalmologist should provide documentation of the retinal hemorrhages by photography or detailed annotated drawings. Location, depth, and extent of retinal hemorrhages may distinguish between abusive and nonabusive causes of head trauma.[48] Retinal hemorrhages occur in approximately 85% of infants and children who are subjected to abusive, repetitive, acceleration-deceleration (shaking) forces with or without impact.[48] Although newborn infants may have retinal hemorrhages in the superficial nerve fiber layers, most resolve by 2 weeks of age, and most intraretinal hemorrhages resolve by 4 to 6 weeks of age.[49]

Thoracoabdominal Injuries

Inflicted injuries that involve the heart are rare and severe. Rib fractures in infants are usually caused by forceful squeezing of the chest[10]; posterior or lateral rib fractures or multiple rib fractures are especially predictive of abusive trauma.[51] Cardiopulmonary resuscitation, whether performed by experienced or inexperienced individuals, is an unlikely cause of rib fractures[52] or retinal hemorrhages. Acute rib fractures may be associated with shallow breathing attributable to pain and splinting; in severe cases, a fractured rib may puncture the lung. Alterations in respiratory patterns may also signal central nervous system damage or response to pain. Other rare injuries associated with abusive blows or compressive forces to the chest include hemopericardium, cardiac contusions occurring as a result of abusive blows to the chest, and shearing of the thoracic duct resulting in chylothorax.[53,54]

Auscultation, performed before palpation, may reveal decreased or no bowel sounds if the child has sustained intraabdominal injury. If the intestines, liver, or spleen have been ruptured, guarding or abdominal muscle rigidity may be noted on palpation. Abdominal bruising is often not seen, even with severe blows to the abdomen.[55] In 1 study,[56] solid organ injuries were most common in children with accidental and inflicted abdominal trauma, but abused children were more likely to have a hollow viscus injury or both hollow viscus and solid organ injuries than were children with accidental abdominal injuries. In comparison with children who sustain accidental trauma to the abdomen, victims of inflicted intraabdominal injury tend to be younger, are more likely to have delayed presentations to a clinical setting, have a higher mortality rate, and are more likely to have an injury to hollow viscera.[8] Liver and pancreatic enzyme tests are helpful in screening children for abdominal trauma, especially when the child presents with acute symptoms or shortly after the incident has occurred. A urinalysis may also lead to the discovery of unexpected trauma to the urinary tract and kidneys. Radiographic studies, including computed tomography, are helpful in determining the types and severity of intraabdominal trauma and are warranted in most cases when the physical examination is unreliable because of patient age, presence of other injuries that may obfuscate the abdominal examination, or the presence of head injury.

Skeletal Injuries

Careful palpation of the legs, arms, feet, hands, ribs, and head may reveal acute or healing (callus formation) fractures. If a fracture is suspected, surfaces should be carefully examined for "grab marks" that may indicate restraint or areas that were pulled or twisted to create the fracture; however, absence of such bruising does not exclude abusive mechanisms of injury. Soft tissue swelling, with or without bruising, may indicate more recent trauma. Many

fractures, including rib and metaphyseal fractures, may not be clinically detectable, so a negative clinical examination should not preclude the need for a skeletal radiologic survey when inflicted trauma is suspected, particularly in children younger than 2 years.

Long-bone fractures that should be evaluated carefully for nonaccidental causes include metaphyseal fractures and spiral/oblique fractures, especially in nonambulatory infants; both types of fractures have been associated with accidental mechanisms of injury as well. Accidental causes of lower-extremity spiral or oblique fractures have been described among infants in "exersaucers"[57] and in the tibia of newly ambulatory toddlers.[58] Osteogenesis imperfecta is a rare congenital disorder that typically presents with bone fragility. Other associated findings are common and include deep-blue sclera, ligamentous laxity, osteopenia, wormian skull bones, dentinogenesis imperfecta, positive family history, and hearing loss. Less common types of this disease may present with fewer and less-severe clinical symptoms.[59] Patients with osteogenesis imperfecta are often suspected as victims of abuse before diagnosis, because the history of the injury insufficiently explains the severity of the fracture, and osteopenia may be lacking in occult cases of this disease.[60]

A complete neurologic assessment, including reflexes, cranial nerves, sensorium, gross motor, and fine motor abilities, should be conducted. Abnormalities may reflect current or past injuries to the central nervous system. Abused children may also have developmental disabilities because of deprivation in the home environment or other causes.

DIAGNOSTIC TESTING AND CONSULTATIONS

When abuse is suspected as the cause of an injury, the clinician may conduct tests to screen for other injuries or underlying medical causes for the injury. The extent of diagnostic testing depends on several factors including the severity of the injury, the type of injury, the age of the child, and examination findings. In general, the more severe the injury and younger the child, the more extensive is the need for diagnostic testing for other injuries. Table 1 is a summary of tests, some of which may be used during a medical assessment for suspected abuse.

View this table:
in this window
in a new window

TABLE 1

Diagnostic Tests That May Be Used in the Medical Assessment of Suspected Physical Abuse and Differential Diagnoses

When 1 child is identified as a suspected victim of abuse, siblings and other child contacts of the suspected abuser should also be assessed for injuries. The extent of the assessment depends on the child's age, symptoms, and signs; infants and toddlers may require more extensive testing, because symptoms and signs may be less useful in determining the presence of occult inflicted injuries.

DOCUMENTATION AND DIAGNOSTIC CONSIDERATIONS

Complete documentation of visible injuries on body diagrams and with photographs is strongly urged and facilitates peer review as well as court testimony, when required. In some regions, investigators from law enforcement or child protective services are specially trained to take forensic photographs. Diagnostic impressions should address whether the explanation adequately correlates with the severity, age, pattern, and distribution of the injury or injuries and the likelihood of nonaccidental causes for the injury. If a child has sustained a serious injury because he or she was left unsupervised in a dangerous environment, the physician should report suspected neglect or inappropriate adult supervision, including injuries sustained while under the care of an intoxicated adult, to child protective services.[61] When the child is evaluated or tested for other nonabusive causes, documentation should reflect the results of this assessment as well. In general, concern for abuse is greatest for infants younger than 12 months regardless of the severity of the injury.

TREATMENT

Once medical assessment and stabilization are achieved and a referral has been made to investigative agencies, the physician should ensure that the child receives the necessary follow-up services. The child's primary care physician should be notified, and child protective services should ensure that the family complies with the plan of care. These services should not only include referral to appropriate medical providers but also address the psychological effects of abuse or neglect on the young child, the siblings, and the nonoffending caregiver. Because adult-partner violence commonly co-occurs with child abuse, several family members may require medical and mental health assistance. Medical passports, which are abbreviated medical chart forms usually kept by foster parents and presented at each medical visit, are recommended to optimize treatment regimens in children who are shifted among agencies and individuals during the course of the child abuse investigation.[70]

LEGAL ISSUES

All 50 states have statutes that mandate reporting of suspected child abuse and neglect; the physician is not required to prove abuse before reporting. Familiarity with state laws will ensure that physicians report to the appropriate agency within the required time frame; some states have provided the option of making such a report through the Internet. Information on specific state laws are provided by the Children's Bureau (Administration for Children and Families, US Department of Health and Human Services; see www.childwelfare.gov/systemwide/laws_policies/search/index.cfm). Many states have laws that permit physicians to evaluate children who are suspected victims of abuse, to conduct tests, and to take photographs without parental consent.

The physician may be required to write a sworn statement of his or her findings and to testify in civil or criminal trial proceedings. Civil hearings include testimony about the safety of the child and the need for appropriate placement with caregivers or state agencies. Judgments are based on a "preponderance of the evidence" with respect to the likelihood of abuse. Criminal hearings involve testimony about the guilt or innocence of an individual with respect to causing the injuries in a child. The burden of proof is greater than that of civil hearings; cases must be proven "beyond a reasonable doubt." Physicians are expected to testify to the facts on the basis of their knowledge and experience in pediatrics and, when appropriate, in child abuse. As such, they may be asked to render opinions regarding the normal developmental capabilities of children at certain ages as well as the mechanisms of injury, severity of the injury, and prognosis. Pediatricians should not testify to anything that is beyond their level of knowledge or expertise. Physicians act primarily as scientists and educators in legal settings rather than as child advocates.

CONCLUSIONS

Child physical abuse is a common problem of childhood. The physician must be able to recognize suspicious injuries, conduct a comprehensive and careful examination with appropriate auxiliary tests, critically assess the explanation provided for the injury or injuries, and establish the probability that the explanation does or does not correlate with the pattern, severity, and/or age of the injury or injuries. The physician is responsible for reporting suspected abuse, documenting his or her opinions clearly, and providing the necessary information and expertise to investigative and legal personnel and parents, when appropriate. In addition, pediatricians are uniquely qualified to work with parents and caregivers to prevent abuse by providing anticipatory guidance on normal child behavior and its management. Finally, physicians must advocate that children in foster care who have medical or mental health problems receive the appropriate services and medications and continuity of care through a medical home, and that a medical passport is maintained for these children.

COMMITTEE ON CHILD ABUSE AND NEGLECT, 2006–2007

Carole Jenny, MD, MBA, Chairperson

Cindy W. Christine, MD

Roberta A. Hibbard, MD

Nancy D. Kellogg, MD

Betty S. Spivack, MD

John Stirling, Jr, MD

LIAISONS

David L. Corwin, MD

American Academy of Child and Adolescent Psychiatry

James A. Mercy, PhD

Centers for Disease Control and Prevention

STAFF

Tammy Hurley

FOOTNOTES

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.
The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate

REFERENCES

1. US Department of Health and Human Services. Administration on Children, Youth, and Families. *Child Maltreatment 2004*. Washington, DC: US Government Printing Office; 2006
2. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the Adverse Childhood Experiences Study. *Pediatrics*.2003;111 :564- 572 Abstract/FREE Full Text
3. Plaza JA, Shaid AD, Smith MA, Russell MD. A reanalysis of the frequency of child abuse seen in pediatric emergency rooms. *Child Abuse Negl*.1987;11 :193- 200 CrossRef Medline Web of Science
4. Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma (published correction appears in *JAMA*. 1999;282:29). *JAMA*.1999;281 :621- 626 Abstract/FREE Full Text
5. Panel on Research on Child Abuse and Neglect. Commission on Behavioral and Social Sciences and Education National Research Council. *Understanding Child Abuse and Neglect*. Washington, DC: National Academy Press; 1993:208
6. Rogers RM, Sean B. Childhood head injuries: accidental or inflicted. *Arch Pediatr Adolesc Med*.2000;154 :11- 15 Abstract/FREE Full Text
7. Feldman KW, Bethel R, Shugerman RP, Cornelison DC, Grady MS, Fitenbaugh RG. The cause of infant and toddler subdural hemorrhage: a prospective study. *Pediatrics*.2001;108 :636- 646 Abstract/FREE Full Text
8. Canty TG Sr, Canty TG Jr, Brown C. Injuries of the gastrointestinal tract from blunt trauma in children: a 17-year experience at a designated pediatric trauma center. *J Trauma*.1999;46 :234- 240 Medline Web of Science
9. Kolko DJ. Characteristics of child victims of physical violence: research findings and clinical implications. *J Interpers Violence*.1992;7 :244- 276 Abstract/FREE Full Text
10. Perry CM, Widom CS. Childhood victimization and long-term intellectual and academic outcomes. *Child Abuse Negl*.1994;18 :617- 633 CrossRef Medline Web of Science
11. Finkelhor D, Ormrod R, Turner H, Hamby SL. The victimization of children and youth: a comprehensive, national survey (published correction appears in *Child Maltreat*. 2005;10:207). *Child Maltreat*.2005;10 :5- 25 Abstract/FREE Full Text
12. National Center on Child Abuse and Neglect. *Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect*. Washington, DC: US Department of Health and Human Services, Administration on Children, Youth, and Families; 1988

13. Wu SS, Ma CX, Carter RL, et al. Risk factors for infant maltreatment: a population-based study. *Child Abuse Negl*.2004;28 :1253- 1264 CrossRef Medline Web of Science

14. Schnitzer PG, Dalaman BG. Child deaths resulting from inflicted injuries: household risk factors and perpetrator characteristics. *Pediatrics*.2005;116 (5). Available at: www.pediatrics.org/cgi/content/full/116/5/e687

15. US Department of Health and Human Services. *A Report on the Maltreatment of Children With Disabilities*. Washington, DC: Westat Inc and James Bell Associates Inc; 1993, Publication 105-89-1630

16. Hindana M, Kanlan B. Clinical response to child abuse. *Pediatr Clin North Am*.2006;53 :27- 39 CrossRef Medline Web of Science

17. Ballweid SA, van der Wal MF, Bruinsma F, Cline RA, Verlooso-Vanhorick SP. Infant crying and abuse. *Lancet*.2004;364 :1340- 1342 CrossRef Medline Web of Science

18. Barr RG, Trent RB, Cross J. Age-related incidence curve of hospitalized shaken baby syndrome cases: convergent evidence for crying as a trigger to shaking. *Child Abuse Negl*.2006;30 :7- 16 CrossRef Medline Web of Science

19. Theodore AD, Chang JJ, Runyan DK, Hunter WM, Bangdiwala SI, Agans R. Epidemiologic features of the physical and sexual maltreatment of children in the Carolinas. *Pediatrics*.2005;115 (3). Available at: www.pediatrics.org/cgi/content/full/115/3/e331

20. Rumm PD, Cummings P, Krauss MR, Bell MA, Rivara FP. Identified spouse abuse as a risk factor for child abuse. *Child Abuse Negl*.2000;24 :1375- 1381 CrossRef Medline Web of Science

21. Ricci L, Ganesh A, Meriam P, Hodge S, Davis T. Abusive head trauma in Maine infants: medical, child protective, and law enforcement analysis. *Child Abuse Negl*.2003;27 :271- 289 CrossRef Medline Web of Science

22. Skellern CY, Wood DO, Murphy A, Crawford M. Non-accidental fractures in infants: risk of further abuse. *J Paediatr Child Health*.2000;36 :590- 592 CrossRef Medline Web of Science

23. Wharton RH, Rosenberg S, Sheridan RL, Ryan DP. Long-term medical consequences of physical abuse. In: Reece RM, ed. *Treatment of Child Abuse: Common Ground for Mental Health, Medical, and Legal Practitioners*. Baltimore, MD: Johns Hopkins University Press; 2000:117- 134

24. Duhaime-Ingrassia L, Kramer L, Prasad M, et al. Neuroimaging, physical, and developmental findings after inflicted and noninflicted traumatic brain injury in young children. *Pediatrics*.1998;102 :300- 307 Abstract/FREE Full Text

25. National Association of Children's Hospitals and Related Institutions. *Defining the Children's Hospital Role in Child Maltreatment*. Alexandria, VA: National Association of Children's Hospitals and Related Institutions; 2006

26. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. Guidance for effective discipline [published correction appears in *Pediatrics*, 1998;102:493]. *Pediatrics*.1998;101 :723 - 728 Abstract/FREE Full Text

27. American Academy of Pediatrics, Committee on School Health. Corporal punishment in schools. *Pediatrics*.2000;106 :343 Abstract/FREE Full Text

28. American Academy of Pediatrics, Committee on Hospital Care and Committee on Child Abuse and Neglect. Medical necessity for the hospitalization of the abused and neglected child. *Pediatrics*.1998;101 :715- 716 Abstract/FREE Full Text

29. Warrington SA, Wright CM; AI SPAC Study Team. Accidents and resulting injuries in mobile infants: data from the AI SPAC study. *Arch Dis Child*.2001;85 :104- 107 Abstract/FREE Full Text

30. Johnson K, Fischer T, Chapman S, Wilson B. Accidental head injuries in children under 5 years of age. *Clin Radiol*.2003;60 :464- 468 CrossRef Medline Web of Science

31. Leventhal JM. Thinking clearly about evaluations of suspected child abuse. *Clin Child Psychol Psychiatry*.2000;5 :139- 147 CrossRef

32. Knel RS. Failure to thrive and fatal injury as a continuum. *Am J Dis Child*.1969;118 :565- 567 Abstract/FREE Full Text

33. Black RW, Krebs NF; American Academy of Pediatrics, Committee on Child Abuse and Neglect, Committee on Nutrition. Failure to thrive as a manifestation of child neglect. *Pediatrics*.2005;116 :1234- 1237 Abstract/FREE Full Text

34. Kellum ND, Lukefahr JL. Criminally prosecuted cases of child starvation. *Pediatrics*.2005;116 :1309- 1316 Abstract/FREE Full Text

35. Maguire S, Mann MK, Sibert J, Kemp A. Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? A systematic review. *Arch Dis Child*.2005;90 :182- 186 Abstract/FREE Full Text

36. Sinal M, Taylor J, Feldman K; Puget Sound Pediatric Research Network. Bruises in infants and toddlers: those who don't cruise rarely bruise. *Arch Pediatr Adolesc Med*.1999;153 :399- 403 Abstract/FREE Full Text

37. Caims AM, Mok JY, Welbury RR. Injuries to the head, face, mouth and neck in physically abused children in a community setting. *Int J Paediatr Dent*.2005;15 :310- 318 CrossRef Medline

38. Kellogg ND; American Academy of Pediatrics, Committee on Child Abuse and Neglect. Oral and dental aspects of child abuse and neglect. *Pediatrics*.2005;116 :1565- 1568 Abstract/FREE Full Text

39. Wagner GN. Bitemark identification in child abuse cases. *Pediatr Dent*.1986;8 :96- 100 Medline

40. Maguire S, Mann MK, Sibert J, Kemp A. Can you age bruises accurately in children? A systematic review. *Arch Dis Child*.2005;90 :187- 189 Abstract/FREE Full Text

41. Orano DA. Kitchen acids and thermal burns in children five years and younger. *Pediatrics*.2005;115 :10- 16 Abstract/FREE Full Text

42. Leventhal JM, Griffin D, Duncan KO, Starling S, Christian CW, Kulz T. Laxative-induced dermatitis of the buttocks incorrectly suspected to be abusive burns. *Pediatrics*.2001;107 :178- 179 FREE Full Text

43. Alexander RC, Levitt CJ, Smith W. Abusive head trauma. In: Reece RM, Ludwig S, eds. *Child Abuse: Medical Management and Diagnosis*. 3rd ed. Philadelphia, PA: Lippincott, Williams & Wilkins; 2001:47-80

44. Greenes DS, Schutzman SA. Clinical indicators of intracranial injury in head-injured infants. *Pediatrics*.1999;104 :861- 867 Abstract/FREE Full Text

45. Laskey AL, Holubkov R, Runyan DK, Sprague BR. Occult head trauma in young suspected victims of physical abuse. *J Pediatr*.2004;144 :719- 722 Medline Web of Science

46. Greenes DS, Schutzman SA. Head trauma in children younger than 2 years: are there predictors for complications. *Arch Pediatr Adolesc Med*.1999;153 :15- 20 Abstract/FREE Full Text

47. Kleinman PK, Barnes PD. Head trauma. In: Kleinman PK, ed. *Diagnostic Imaging of Child Abuse*. 2nd ed. St Louis, MO: Mosby Inc; 1998:293

48. Morad Y, Kim YM, Armstrong DC, Hoyt CS, Miller M, Levin AV. Correlation between retinal abnormalities and intracranial abnormalities in the shaken baby syndrome. *Am J Ophthalmol*.2002;134 :354- 359 CrossRef Medline Web of Science

49. Emerson MV, Pierpaoli CL, Stroebel KM, Berreen JP, Gariano RF. Incidence and rate of disappearance of retinal hemorrhage in newborns. *Ophthalmology*.2001;108 :36- 39 CrossRef Medline Web of Science

50. Bulloch B, Schubert CJ, Brophy PR, Johnson N, Reed MH, Shankle RA. Cause and clinical characteristics of rib fractures in infants. *Pediatrics*.2000;105 (4). Available at: www.pediatrics.org/cgi/content/full/105/4/e48

51. Barnes KA, Cha PS, Ramaswamy RD, et al. The positive predictive value of rib fractures as an indicator of nonaccidental trauma in children. *J Trauma*.2003;54 :1107- 1110 Medline Web of Science

52. Stevens MR, Kleinman PK, Ratzenhofer PI, Primack C, Richmond JM. Cardiopulmonary resuscitation and rib fractures in infants: a postmortem radiologic-pathologic study. *JAMA*.1994;272 :617- 618 Abstract/FREE Full Text

53. Karnes A, Yen K, Sell LL, Frommelt PC. Severe blunt cardiac injury in an infant: a case of child abuse. *J Trauma*.2002;52 :759- 764 Medline Web of Science

54. Guiberteau KJ, Gilchrist JE, Luks FI, Wesselhoeft CW, Deluca FG. Child abuse as a cause of traumatic chylothorax. *J Pediatr Surg*.1996;31 :1696- 1697 CrossRef Medline Web of Science

55. Thomson S. Accidental or inflicted? Evaluating cutaneous, skeletal, and abdominal trauma in children. *Pediatr Ann*.2003;34 :372- 381 Medline Web of Science

56. Wood L, Rubin DM, Nance ML, Christian CW. Distinguishing inflicted versus accidental abdominal injuries in young children. *J Trauma*.2005;59 :1203- 1208 Medline Web of Science

57. Grant P, Mata MR, Tidwell M. Femur fracture in infants: a possible accidental etiology. *Pediatrics*.2001;108 :1009- 1011 Abstract/FREE Full Text

58. Halsey MF, Floyd KC, Carvan WV, Haralabatos SR, Gruber MA, Meinhard BP. Toddler's fracture: presumptive diagnosis and treatment. *J Pediatr Orthop*.2001;21 :152- 156 CrossRef Medline Web of Science

59. Black RW. Child abuse: controversies and imposters. *Curr Probl Pediatr*.1999;29 :249- 272 Medline

60. Jenny C: American Academy of Pediatrics. Committee on Child Abuse and Neglect. Evaluating infants and young children with multiple fractures. *Pediatrics*.2006;118 :1299- 1303 Abstract/FREE Full Text

61. Ingram JD. Connelli. Hay TC. et al. Oblique radiography of the chest in nonaccidental trauma. *Emerg Radiol*.2000;7 :42- 46 CrossRef

62. American Academy of Pediatrics. Section on Radiology. Diagnostic imaging of child abuse. *Pediatrics*.2000;105 :1345- 1348 Abstract/FREE Full Text

63. Kleinman PK. Nimkin K. Spevak MR. et al. Follow-up skeletal surveys in suspected child abuse. *AJR Am J Roentgenol*.1996;167 :893- 896 Abstract/FREE Full Text

64. Hymel KP. Abshire TC. Luckey DW. Jenny C. Coagulopathy in pediatric abusive head trauma. *Pediatrics*.1997;99 :371- 375 Abstract/FREE Full Text

65. Chant PN. Knonhorn AF. Brady AS. Edwards-Holmes K. Markers for occult liver injury in cases of physical abuse in children. *Pediatrics*.1992;89 :274- 278 Abstract/FREE Full Text

66. Partikl PM. Cecilemans B. Laridon A. Ozsarlak O. Van Goethem JW. Iorens PG. Cortical ischemic-ischemic brain damage in shaken-baby (shaken impact) syndrome: value of diffusion-weighted MRI. *Pediatr Radiol*.2003;33 :668- 671 CrossRef Medline Web of Science

67. Morad Y. Avni I. Benton SA. et al. Normal computerized tomography of brain in children with shaken baby syndrome. *J AAPOS*.2004;8 :445- 450 CrossRef Medline

68. Kelner MD. Zimmerman RA. Bilaniuk LT. MRI in the assessment of the nonpenetrating tissues of the cervical spine in acute trauma in children. *Neuroradiology*.1998;40 :359- 369 CrossRef Medline Web of Science

69. Hymel KP: American Academy of Pediatrics. Committee on Child Abuse and Neglect. When is lack of supervision neglect? *Pediatrics*.2006;118 :1296- 1298 Abstract/FREE Full Text

70. American Academy of Pediatrics. Committee on Early Childhood. Adoption. and Dependent Care. Health care of young children in foster care. *Pediatrics*.2002;109 :536- 541 Abstract/FREE Full Text

Copyright © 2007 by the American Academy of Pediatrics

Responses to this article

Eye findings and Allegations of Shaking and Non-Accidental Injury
John G Galazzik
Pediatrics published online August 8, 2007
»Full Text

Statement of reaffirmation:

From the American Academy of Pediatrics:
Policy Statement: AAP Publications Reaffirmed and Retired
Pediatrics 2012; 130:2 e467-e468; published ahead of print July 30, 2012, doi:10.1542/peds.2012-1359
»Extract »Full Text »Full Text (PDF)

Articles citing this article

Prevalence of Abusive Injuries in Siblings and Household Contacts of Physically Abused Children
Pediatrics 2012; 130:2 193-201
»Abstract »Full Text »Full Text (PDF)

Prevalence of Retinal Hemorrhages in Critically Ill Children
Pediatrics 2012; 129:6 e1388-e1396
»Abstract »Full Text »Full Text (PDF)

Symptoms and Time to Medical Care in Children With Accidental Extremity Fractures
Pediatrics 2012; 129:1 e126-e133
»Abstract »Full Text »Full Text (PDF)

Detection of child abuse in emergency departments: a multi-centre study
Arch. Dis. Child. 2011; 96:5 422-425
»Abstract »Full Text »Full Text (PDF)

Vitamin D Status in Abused and Nonabused Children Younger Than 2 Years Old With Fractures
Pediatrics 2011; 127:5 835-841
»Abstract »Full Text »Full Text (PDF)

Evaluation of the Siblings of Physically Abused Children: A Comparison of Child Protective Services Caseworkers and Child Abuse Physicians
Child Maltreat 2010; 15:2 144-151
»Abstract »Full Text (PDF)

Bruising Characteristics Discriminating Physical Child Abuse From Accidental Trauma
Pediatrics 2010; 125:1 67-74
»Abstract »Full Text »Full Text (PDF)

Child Abuse Fatalities: Pattern of Injury
AAP Grand Rounds 2009; 22:5 31
»Full Text »Full Text (PDF)

Utility of Hepatic Transaminases to Recognize Abuse in Children
Pediatrics 2009; 124:2 509-516
»Abstract »Full Text »Full Text (PDF)

Multiple fractures due to osteogenesis imperfecta mistaken as child abuse
BMJ Case Reports 2009; 2009:mar19_1 bcr0720080589
»Abstract »Full Text

Forty years later: inconsistencies in reporting of child abuse
Arch. Dis. Child. 2008; 93:10 822-824
»Full Text »Full Text (PDF)

Medical Conditions Affecting Sports Participation
Pediatrics 2008; 121:4 841-848
»Abstract »Full Text »Full Text (PDF)

Diagnostic Evaluation for Suspected Child Abuse
JWatch Pediatrics 2007; 2007:620 4
»Full Text

Uncovering child abuse: Physical abuse is an underreported and often unnoticed problem. A new clinical report outlines the critical components of the medical assessment.
AAP News 2007; 28:6 9-10
»Full Text »Full Text (PDF)

EXHIBIT

"8"

PLAINTIFF'S EXHIBIT 7

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:30 pm

Count No 339-00397 | Name [redacted] | Unit Number 000545-02 19 | Birthdate [redacted]

1)Date : [redacted]
2)Init : KAH
3)Planning Code : CPSI-CPS1-CHILD PROT SVC. INITIAL REFER
4)Referred From : LCH

1 2 3 4 5 6 7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345

1206/2009 ~1500 MSW received page re r/o NAT, work-up is negative for NAT but pt does have a small subdural hematoma. Sara, RN reports that parents have been appropriate, grandparents have been visiting. MSW met c parents. Mom is Kayla Lythgoe, dad is Michael Carcuff, baby lived c both parents. Baby lives at [redacted], Rock Hill, SC 29732. parents do not have a home phone, only a cell phone c texting, [redacted], phone # [redacted] listed on demographic sheet belongs to MGM Charlotte Williams. Pt's parents report that on Weds. 12/02/2009, parents noticed that baby "not seeming like himself, sleepy more than usual" "screaming non-stop" "funky smell out of his mouth" took the baby to Sunshine Pediatrics, to see Dr. Paxton, who told the parents that it was a viral infection and to give the baby Tylenol every 6 hours. On Friday night 12/04/2009 (note con dt. Notes (Y/N)?-

EXHIBIT 8

CMC (12.05.09) 0092

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:41 pm

Account No
09339-00393 [redacted]

Unit Number Birthdate
000545-02-09 [redacted]

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
(4)Referred From : LCH

```
         1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234
01 12/06/2009 MSW note continued...after she staffs the case c her supervisor
02 Baby is not for d/c today, possibly will be d/ced tomorrow. Baby does have
03 SC Medicaid, WIC, mom has foodstamps. Both parents work, MGM watches baby
04 when parents are working. Pt's bedside RN Sara did report that MGM did
05 tell her privately that when she had picked baby up from dad and uncle
06 that she noticed baby had a bump on his head, she asked dad and uncle
07 about this and dad and uncle stated that they had no idea why this
08 happened. MSW will leave note for weekday MSW.
09
10 Katie Harrison, MSW p 2527
11
12
Edit Notes (Y/N)?--
```

CMC (12.05.09) 0096

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 06:44 pm

Account No [redacted] Unit Number Birthdate [redacted]

)9339-00393 000545-02-19

(1)Date : 12/06/09

(2)Init : KAH

(3)Planning Code : CPSA-CPSA-CHILD PROT SVC ACCEPTANCE

(4)Referred From : LCH

```
         1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234
01 12/06/2009 -1830 MSW received phone call from Shandra Tyler, DSS York Cty,
02 Ms. Tyler will be coming to the hospital to do an assessment. MSW will
03 notify Sherry Deedrick, MSW ED SW. MSW d/w Sara, RN who has the pt, Sara
04 does not feel parents are a flight risk and will let parents know that the
05 DSS worker is coming out to meet c the parents. MSW will follow as needed.
06 For any questions this evening, please contact Sherry Deedrick, ED MSW at
07 p1436.
08
09 Katie Harrison, MSW p 6703
10
11
12
Edit Notes (Y/N)?--
```

CMC (12.05.09) 0095

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:36 pm

Account No [redacted] Unit Number 000565-02-19 Birthdate [redacted]

09339-00393

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER
(4)Referred From : LCH

```
         1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456
01 12/06/2009 MSW note continued...dad noted that pt was sleeping more than
02 usual, woke up crying, then "stretched out, went limp but was still
03 breathing." Dad took baby to Piedmont Hospital, baby was limp during the
04 ride there, wimpered a little, did not open his eyes and when he handed
05 the baby to the nurse at Piedmont, baby screamed. Baby was evaluated at
06 Piedmont and was transferred to LCH early Saturday morning. Parents are
07 aware that a full body x-ray was done and that pt has "blood on the right
08 side of his brain." Parents deny any trauma, that anyone dropped the baby.
09 pt's birth was normal, full-term. Baby is only watched by parents and
10 maternal grandmother, no daycare. Baby is bottle fed. MSW contacted York
11 DSS after hours 803-628-3056 and received a call from on-call DSS worker
12 Shandra Taylor who took the report and will call MSW back. (MSW note conti
Edit Notes (Y/N)?--
```

CMC (12.05.09) 0097

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 05:30 pm

Account No [redacted] Unit Number Birthdate

09339-00393 000545-02-19 [redacted]

(1)Date : 12/06/09

(2)Init : KAH

(3)Planning Code : CPSI-CPSI-CHILD PROT SVC INITIAL REFER

(4)Referred From : LCH

1 2 3 4 5 6 7

1234567890123456789012345678901234567890123456789012345678901234567890123456789012345

01 1206/2009 ~1500 MSW received page re r/o NAT, work-up is negative for NAT
02 but pt does have a small subdural hematoma. Sara, RN reports that parents
03 have been appropriate, grandparents have been visiting. MSW met c parents,
04 mom is Kayla [redacted] dad is Michael Carduff, baby lives c both parents.
05 Baby lives at [redacted], Rock Hill, SC 29732, parents do not
06 have a home phone, only a cell phone c texting, [redacted], phone # [redacted]
07 listed on demographic sheet belongs to MGM Charlotte Williams
08 Pt's parents report that on Weds. 12/02/2009, parents noticed that baby
09 "not seeming like himself, sleepy more than usual" "screaming non-stop"
10 "funky smell out of his mouth" took the baby to Sunshine Pediatrics, to
11 see Dr. Paxton, who told the parents that it was a viral infection and to
12 give the baby Tylenol every 6 hours. On Friday night 12/04/2009 (note con,
Edit Notes (Y/N)?--

CMC (12.05.09) 0098

Carolinas Patient Care Discharge Planning Processor

Mon Dec 07, 2009 12:03 pm

\ccount No [redacted] Unit Number Birthdate [redacted]

)9339-00393 000545-02-19

(1)Date : 12/07/09

(2)Init : LHN

(3)Planning Code : ASES-ASSESSMENT - INITIAL

(4)Referred From : LCH

```
         1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234
01 Met c parents at bedside to confirm DSS visit.  Met c worker from york co.
02 12/6 and signed safety plan, anticipate d/c hopefully this date.  [redacted]
03 lives c parents, no other children, does have Medicaid, WIC,
04 transportation, frequent babysitting c mat g'mother.  Both parents
05 employed, father has finished 10th grade, mother 11th, MSW discussed safe
06 sleeping, other parenting education available for parents prior to d/c.
07 Parents c questions about DSS investigation, MSW explained that DSS will
08 complete home visits upon d/c, will assist c medical follow up if needed.
09 No other questions, will follow for safe d/c plan.  Updated RN, MD.
10
11 Laura Newmark, MSW 58720 [signature] MSW
12 12/7/09  1030
```

F1	F2	F3	F4	F5	F6	F7	F10
Delete Line	Insert Line	Center	Exit	Store Line	Restore Line	Pack	Help

CMC (12.05.09) 0094

Carolinas Patient Care Discharge Planning Processor

Mon Dec 07, 2009 12:07 pm

Account No [redacted] Unit Number Birthdate

09339-00393 000545-02-19 [redacted]

(1)Date : 12/07/09

(2)Init : LHN

(3)Planning Code : CPSU-CPSU-CHILD PROT SVC UPDATE

(4)Referred From : LCH

1 2 3 4 5 6 7

1234567890123456789012345678901234567890123456789012345678901234

01 MSW spoke c worker Christa Hinnant 803-684-8154 re. patient condition, NAT
02 workup. Optho (-), NAT series (-), no other obvious signs of abuse,
03 neglect. MSW spoke c attending Dr. Courtlandt re. likely inability to
04 confirm NAT d/t limited findings, would like to have ongoing DSS
05 involvement c investigation, home visit, parenting education, f/u NAT
06 series in two weeks as outpt. Owen to have repeat CT scan today, no clear
07 d/c date. DSS to staff c attorney, but likely will allow d/c home c
08 parents. Child Maltreatment Coordinator has seen child as well, Nsg
09 following. Updated RN Tracey. Will follow.
10
11 Laura Newmark, MSW 58788 MSW
12 12/7/09 1200

F1 Delete Line | F2 Insert Line | F3 Center | F4 Exit | F5 Store Line | F6 Restore Line | F7 Pack | F10 Help

CMC (12.05.09) 0093

EXHIBIT

"9"

Piedmont Medical Center - Rock Hill, SC 29732

Patient:	[redacted]	DOB:	[redacted]
MR #:	000345331	Age/Gender:	12w M
DOS:	12/4/2009 17:12	Acct #:	[redacted]
Private Phys:	Sunshine Pediatrics	ED Phys:	Christopher DiOrio, DO

Past Medical/Surgical History
Amendments to history obtained earlier:
FT/SVD at no pre, peri or post natal complications
"throat infection" diagnosed by Pediatrician Dr paxtor

Daycare none, no smokers in housem first child <CD3 12/04/09 19:34>
No significant medical history. <RS 12/04/09 18:54>
No significant surgical history. <RS 12/04/09 18:54>

Past Social History
Patient does not use drugs. <RS 12/04/09 18:54>
Patient does not use alcohol. <RS 12/04/09 18:54>
Patient does not use tobacco. <RS 12/04/09 18:54>

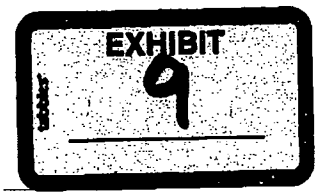
HISTORY OF PRESENT ILLNESS

Note
Medical Screening examination has been initiated.

Notes: seen with mother and father and gmother <CD3 12/04/09 19:32>
Medical and surgical history obtained. <CD3 12/04/09 18:57>
Social history obtained. <CD3 12/04/09 18:57>
Past family history obtained. <CD3 12/04/09 18:57>
HPI: A12 week old white male presents with "lethargic, not responsive and we thought he was dead."
Per mother and more specifically father who is with the child at the time of the incident, the patient was nonresponsive but still breathing and had good pulses and no cyanosis for a period of 5 to 10 minutes. Father states that the child got tense and quite possibly had a tonic episode with no clonic activity and subsequently was not arousable to gentle shakes or further stimuli.
They state the child has been having a poor appetite, and mildly "lethargic" which they describe as less crying more irritable over the past 24 hours.

ROS: As documented in HPI. All other symptoms are negative.

PE:
GENERAL: well appearing; well nourished; in no apparent distress; non-toxic, this is a "great" looking child very healthy with a strong suckle on my gloved finger
HEAD: normocephalic; atraumatic
EYES: PERRL; EOM intact
ENT: normal nose; no rhinorrhea; mucous membranes moist; pharynx clear
NECK: supple; trachea midline; non-tender
CARDIAC: RRR; S1, S2; no appreciable murmurs, rubs or gallops
LUNGS: breath sounds clear and equal bilaterally; no appreciable wheezes, rales or rhonchi
ABDOMEN: soft; non-tender; non-distended; no appreciable organomegaly
bilateral descended testes with a circumcised penis



EXHIBIT

"10"

Name: Michael Cardwell DOB: [redacted] Phone # _____
Address: [redacted] Phone # _____
RHSC
City: _____ State: _____ Zip: _____

YORK COUNTY SHERIFF'S OFFICE Incident Report No: _____
Voluntary Statement

VOLUNTARY STATEMENT

I, Michael Cardwell, know and understand my rights. Having decided to answer questions at this time, I now make the following statement.

1) I DID NOT TELL anyone that I dropped
2) [redacted] I DIDN't want Kayla to Put
3) me back out the house. I was Scared
4) I didn't Know what to do I thought
5) he was fine. the only other thing
6) That I admit to is Sometime in the
7) Past I would get frustrated with
8) [redacted]'s Crying and Pat him in the
9) back hard.
10)
11)
12)
13)
14)
15)
16)

The statement above, consisting of 3 page(s), is made of my own free will. No one has threatened me in any way or promised me special treatment to cause me to make this statement. I am signing my name in the space below to show that it is my statement and it is the truth.

Signed: + Michael Cardwell Date: 1-11-10 Time: 9:52p
Witness: Amanda P. Carter Page 3 of 3

YCSO, (09-2000) Form: Statement 1

EXHIBIT 10

EXHIBIT

"11"

Carduff was asked to describe his and Kayla's relationship and their interaction with [redacted] He stated that he and Kayla want to get married someday. He stated that since [redacted] came along things have been a little stressed. He stated that he lost his job in December after missing too much work when [redacted] got sick and had to go to the hospital.

Carduff stated that since he lost his job he and Kayla have been arguing. He stated that she made him leave for a little while. He stated that he stayed with friend in Concord NC during that time. Carduff stated that he was able to move back in about 3 or 4 days ago.

Carduff stated that since he is not working he keeps [redacted] by himself while Kayla works. He stated the she usually goes in at about 3:00 in the afternoon and gets home sometime around 10:30 or 11:00 at night. Carduff stated that when it is just him and [redacted], they watch TV or he might try to get [redacted] to move around in order to help his balance and strength. Carduff stated that [redacted] is a happy baby most of the time. He stated that he sleeps several times during the day and only gets up a few times at night. Carduff stated that sometimes when [redacted] is fussy, he will take him for a ride in the car which usually puts him to sleep.

Carduff was asked to detail his and [redacted] activities for this past Sunday which was the day before [redacted] injuries were discovered. He stated that Kayla took [redacted] to church in the morning. He stated that they just hung around the house until Kayla went to work at about 3:00 that afternoon. He stated that [redacted] was fine most of the day and evening. Carduff stated that [redacted] started getting fussy at about 10:00 in the evening. He stated that he put [redacted] in his car seat and then put him in the car and rode around for awhile trying to get [redacted] to fall asleep. He stated that he and [redacted] got back home at about midnight. He stated that Kayla was at home sitting on the coach. Carduff stated that [redacted] was asleep so he carried him into his bedroom and put him in his crib.

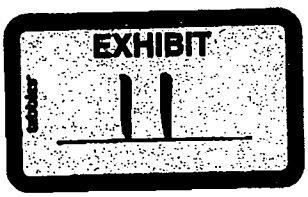
Carduff stated that [redacted] woke up twice during the night and both times he was the one that got up to check on [redacted]. He stated that [redacted] would not eat, but he appeared to be okay.

Carduff stated that Kayla got up to check on [redacted] at about 9:30 am and noticed that he was having seizures. He stated that they took [redacted] to the hospital in Rock Hill and that the doctors there decided that he needed to be flown to Charlotte.

The workings of the polygraph equipment and the testing procedure were explained to Carduff. The questions to be asked on the test were reviewed with him. Carduff was asked if needed to use the restroom and if he wanted a drink of water. He declined the water but did ask to use the restroom. He was escorted to the restroom by Det. Patterson and then back to the polygraph room.

The polygraph test started at approximately 20:10 hrs. and concluded at approximately 20:30 hrs. Carduffs responses to the test questions were indicative of deception.

It was explained to Carduff that he had failed the test and he was asked to explain again how [redacted] had been injured. Carduff began to cry and stated that he had accidently dropped [redacted] while carrying him down the steps this past Sunday night while Kayla was at work. He stated that [redacted] was strapped in his car seat when this happened and that he was going to take [redacted] for a ride to help him go to sleep. Carduff stated that [redacted] was very upset and crying after he was dropped. Carduff stated that he went ahead and put him in the car and tried to calm him down by talking to him. He stated that he rode around with [redacted] until he stopped crying.



EXHIBIT

"12"

Interview with Michael P. Carduff

January 11th, 2010

Moss Justice Center

Det. Doug Patterson

On January 11th, 2010, Michael Carduff reported to the Moss Justice Center to voluntarily take a polygraph examination. The polygraph was in reference to Carduffs four month old son, [redacted] who had sustained head injuries that were consistent with Shaken Baby Syndrome. Carduff, his son, and girlfriend Kayla, live on Gauldens Park Rd. in York County. The polygraph was requested by Lt. W. J. Miller with the York County Sheriff's Office. The case agent on this case was Det. Amanda Carter. The polygraph was to be conducted by Det. Doug Patterson.

Det. Carter escorted Carduff to the polygraph room at approximately 18:50 hrs.

Det. Patterson introduced himself to Carduff as a law enforcement officer. Carduff was provided a form containing the Miranda warning. The rights portion of that form was read to Carduff. He acknowledged verbally and in writing that he understood his rights. Carduff was asked to read, out loud, the waiver portion of the form, he did so with no problem. He acknowledged verbally and in writing that he understood the waiver and that he was willing to talk to police and answer questions.

Carduff was provided a form containing the Consent To Interview With Polygraph. The rights portion of that form was read to Carduff. He acknowledged verbally that he understood his rights. Carduff was asked to read, out loud, the waiver portion of the form, he did so with no problem. He acknowledged verbally and in writing that he understood the waiver and that he agreed to the use of the polygraph.

The extent of [redacted] injuries as known to Det. Patterson were discussed with Carduff. He was asked if he did anything to cause [redacted] injuries, he replied no. He was asked if he knew who had caused [redacted] injuries, he replied no. Carduff did state that he and his wife had discussed [redacted] injuries in private and they did not have any idea how [redacted] was injured. Carduff was asked if understood that [redacted] injuries could not have just happened, that someone had to have did something to [redacted] to cause the injuries, he replied that he knew that was true.

A pre-polygraph work sheet was completed on Carduff. He is an 18 year old white male. He reported that he finished the 11th grade. He reported that he has been unemployed since about the middle of December 2009. Carduff stated that he and his girlfriend Kayla have been together for about 2 years, they have lived together for about a year. Carduff reported that [redacted] is his and Kayla's only child. Carduff reported that he is in good health. He reported that he is taking an antibiotic due to having a tooth pulled about a week ago. He reported that his mouth does not bother him at all. He reported that he does not do any kind of illegal drugs or drank alcoholic beverages. Carduff reported that he was charged with possession of stolen goods when he was 16 years old. He reported that he has no other criminal activity in his past.

Carduff was asked to describe his and Kayla's relationship and their interaction with [redacted]. He stated that he and Kayla want to get married someday. He stated that since [redacted] came along things have been a little stressed. He stated that he lost his job in December after missing too much work when [redacted] got sick and had to go to the hospital.

Carduff stated that since he lost his job he and Kayla have been arguing. He stated that she made him leave for a little while. He stated that he stayed with friend in Concord NC during that time. Carduff stated that he was able to move back in about 3 or 4 days ago.

Carduff stated that since he is not working he keeps [redacted] by himself while Kayla works. He stated the she usually goes in at about 3:00 in the afternoon and gets home sometime around 10:30 or 11:00 at night. Carduff stated that when it is just him and [redacted], they watch TV or he might try to get [redacted] to move around in order to help his balance and strength. Carduff stated that [redacted] is a happy baby most of the time. He stated that he sleeps several times during the day and only gets up a few times at night. Carduff stated that sometimes when [redacted] is fussy, he will take him for a ride in the car which usually puts him to sleep.

Carduff was asked to detail his and [redacted] activities for this past Sunday which was the day before [redacted] injuries were discovered. He stated that Kayla took [redacted] to church in the morning. He stated that they just hung around the house until Kayla went to work at about 3:00 that afternoon. He stated that [redacted] was fine most of the day and evening. Carduff stated that [redacted] started getting fussy at about 10:00 in the evening. He stated that he put [redacted] in his car seat and then put him in the car and rode around for awhile trying to get [redacted] to fall asleep. He stated that he and [redacted] got back home at about midnight. He stated that Kayla was at home sitting on the coach. Carduff stated that [redacted] was asleep so he carried him into his bedroom and put him in his crib.

Carduff stated that [redacted] woke up twice during the night and both times he was the one that got up to check on [redacted]. He stated that [redacted] would not eat, but he appeared to be okay.

Carduff stated that Kayla got up to check on [redacted] at about 9:30 am and noticed that he was having seizures. He stated that they took [redacted] to the hospital in Rock Hill and that the doctors there decided that he needed to be flown to Charlotte.

The workings of the polygraph equipment and the testing procedure were explained to Carduff. The questions to be asked on the test were reviewed with him. Carduff was asked if needed to use the restroom and if he wanted a drink of water. He declined the water but did ask to use the restroom. He was escorted to the restroom by Det. Patterson and then back to the polygraph room.

The polygraph test started at approximately 20:10 hrs. and concluded at approximately 20:30 hrs. Carduffs responses to the test questions were indicative of deception.

It was explained to Carduff that he had failed the test and he was asked to explain again how [redacted] had been injured. Carduff began to cry and stated that he had accidently dropped [redacted] while carrying him down the steps this past Sunday night while Kayla was at work. He stated that [redacted] was strapped in his car seat when this happened and that he was going to take [redacted] for a ride to help him go to sleep. Carduff stated that [redacted] was very upset and crying after he was dropped. Carduff stated that he went ahead and put him in the car and tried to calm him down by talking to him. He stated that he rode around with [redacted] until he stopped crying.

EXHIBIT

"13"

Clinical Member of
SCPA, SCALP, SCAPP
APA, ACFE

Area of Specialty:
Counseling Psychology,
APA Division #17

J. Patrick Goldsmith, Ed.D.
PSYCHOLOGICAL ASSOCIATES, P.A.
Post Office Box 669
Lancaster, South Carolina 29721-0669
Telephone/Facsimile (803) 283-4004

STATE OF SOUTH CAROLINA COUNTY OF YORK	IN THE FAMILY COURT SIXTEENTH JUDICIAL CIRCUIT
South Carolina Department of Social Services, Plaintiff, versus Michael Carduff, Kayla Lythgoe, Charlotte Williams and Larry Williams, Defendants. In the Interest of: [redacted], DOB: [redacted] A Minor Under the Age of 18.	REPORT OF PSYCHOLOGICAL EVALUATION File Book #10-DR-46-314

EVALUATED:

April 19, 2010 19 year-old mother Kayla Lythgoe DOB [redacted]

REFERRAL INFORMATION:

This nineteen year, ten month-old single, Caucasian female was referred for psychological evaluation by Arnette Y. Dye, Human Services Specialist II with the York County office of South Carolina Department of Social Services. One of numerous Recommendations to be submitted to the court by that agency was that Ms. Lythgoe complete a psychological evaluation "and comply with the recommended treatment resulting from the evaluation". Guardian *ad Litem* Lauren McCauley also requested that a psychological evaluation be completed, the purpose being "to determine whether or not she has the maturity and intellectual comprehension to care for a child with the severe and complex needs that Owen now has".

INFORMATION REVIEWED:

DSS forwarded roughly an inch and-a-half of and records pertaining to this case. Included were:

[redacted] 2009	medical records re: birth of [redacted] Piedmont Medical Center, Rock Hill, South Carolina
December 4-5, 2009	medical records from treatment of Owen at Piedmont Medical Center
January 11, 2010	medical records from treatment of Owen at Piedmont Medical Center
January 11, 2010	Affidavit and Arrest Warrant of Michael Patrick Carduff: J-169399, Children/Unlawful Conduct Toward A Child, signed by Judge Leon E. Yard
January 11-20, 2010	Transfer Summary of treatment at Pediatric Intensive Care Unit, Levine Children's Hospital, Carolinas Medical Center, Charlotte, North Carolina
January 20-26, 2010	records of services rendered at Hospice & Community Care, Rock Hill
(no date given)	(2) articles from *The Herald* re: [redacted]
February 10-17	records re: treatment at Carolinas Rehabilitation, Levine Hospital
February 17, 2010	Affidavit of Imminent And Substantial Danger and Affidavit of Reasonable Efforts *Ex-parte* Removal, each signed by Diva Hemphill, Human Services Specialist, South Carolina Department of Social Services, York County office
February 17, 2010	Complaint for *Ex-parte* Removal filed by David E. Simpson, Attorney for Plaintiff, S.C. DSS
February 17, 2010	*Ex-parte* Order of Removal signed by The Honorable Henry T. Woods
March 13, 2010	Special Conditions of Bond Order, Case No.: J-165212, Inflicting Great Bodily Harm Upon A Child, State of South Carolina vs. Michael Patrick Carduff, signed by The Honorable Clayburn S. Burnette, Junior, Bond Court
(undated, unsigned)	S.C. DSS Court Information Sheet/Supplemental Report prepared for 35-Day Removal (Merits) Hearing
c. March 16, 2010	S.C. Guardian *ad Litem* Program Report and Recommendations of the Volunteer GAL, Lauren McCauley
April 22, 2010	telephone consultation with Annette Dye, HSS II, York County DSS

CASE HISTORY:

Charlotte (DOB: [redacted]) and Larry Williams (DOB: [redacted]) are the mother and stepfather of Kayla Lythgoe. The couple lives in Rock Hill, S.C., where Mr. Williams is Senior Pastor at Family Faith Christian Center.

Kayla Lythgoe resided with her paramour, Michael Patrick Carduff (DOB: [redacted]). On [redacted], eighteen year-old Ms. Lythgoe was induced at Piedmont Medical Center and vaginally delivered at forty weeks gestation Owen [redacted], son of nineteen year-old Mr. Carduff. Because she had untreated Group B Strep, Owen spent two days in Neonatal ICU. Mother and son breastfed well, and Owen was to nurse at least every two hours, which would help with Jaundice. Owen passed hearing screenings for both ears before being discharged home on September 11.

The Lythgoe-Carduff family resided at [redacted] in Rock Hill, within walking distance of the Williams. The Williams were very active in the care of [redacted] and frequently babysat. Sitters were only occasionally used, and Mrs. Williams provided childcare for Owen during the day.

On December 4, three month-old [redacted] was taken to PMC "unresponsive and lethargic". After evaluation, he was transferred to the Pediatric Intensive Care Unit of Levine Children's Hospital. There, [redacted] was found to have two subdural hematomas, cause unknown. He was diagnosed with an acute, life-threatening event, rule out non-accidental trauma, and thus on December 6, DSS was notified and became involved. Levine's social worker reported no obvious signs of abuse or neglect, and Levine mostly had concerns for lack of supervision. On December 8, [redacted] was discharged home to his parents with instructions to take special care of him, note and report any changes in his condition and immediately seek medical care if anything unusual occurred at all with him. [redacted] was to return in two weeks for repeat skeletal survey; his parents were to pay close attention to him, not leave him alone or unattended and monitor for changes in mental status, increased lethargy, and onset of vomiting. DSS advised parenting classes and a home evaluation upon discharge.

On Friday, January 9, 2010, Ms. Lythgoe saw a bruise on four month-old [redacted]'s forehead, but told no one and sought no medical attention or follow up. That Saturday and Sunday (10th and 11th), she went to work and Mr. Carduff kept [redacted]. Mr. Carduff admitted that on the night of January 10 or on the 11th, he physically shook [redacted] "out of frustration" and did not notify anyone or seek medical treatment. January 11, after [redacted] began jerking and shaking uncontrollably, he took him to PMC. [redacted] was seizing upon arrival and found to have multiple acute subdural hematomas and multiple bruises on his chest, arms, cheek and legs. Upon inquiry, his mother stated an old, brownish bruise on his upper chest was from "scratching himself". Rock Hill Police were notified for possible abuse and arrived to investigate before [redacted] was airlifted to Levine's PICU on that same date.

Asked at [redacted]'s January 11 admission to Levine about his chest bruise, his parents stated he "must have scratched himself". Mrs. Williams told staff she had seen a "goose egg" on the middle of [redacted]'s forehead on January 9; she had asked Mr. Carduff it had occurred, and he told her [redacted] "must have scratched himself". Per Case Manager Dye, when he was admitted, Ms. Lythgoe stated that she was returning to Rock Hill to get clothing and was gone several hours. Law Enforcement reported she instead drove to Moss Justice to be with Mr. Carduff while he underwent a polygraph.

On January 11, Mr. Carduff was arrested and charged with Unlawful Conduct Toward A Child.

According to Annette Dye, Levine expressed concern that Ms. Lythgoe had no bond with [redacted] and "showed no emotion with him". [redacted] was in critical condition for several days. He seized throughout January 11 and 12 and was found to have bilateral retinal hemorrhages and acute on chronic non-accidental traumatic brain injury with associated neurological deficits. Mrs. Williams informed *The Herald*, to whom she provided at least two interviews, that he could not move, eat or drink. She stated doctors said tests showed 70% of his brain was damaged and he was so badly injured, "If we chose to keep him alive, the doctors told us [redacted] would basically be a vegetable". On January 15, the family requested DNR status. When [redacted] showed increased spontaneous movements on his January 16 exam, family rescinded the DNR. Consulted on January 18 regarding his 1/16 MRI results, Neuroradiology agreed [redacted]'s prognosis was very poor, and on that date, Ms. Lythgoe and the Williams agreed to again withdraw support and make [redacted] DNR/DNI. After extubation, he breathed independently. On the 19th, Ms. Lythgoe requested withdrawal of all care, including fluid and nutritional supplementation. She also decided to transfer [redacted] to a hospice.

On January 20, Ms. Lythgoe and the Williams took [redacted] to Wayne T. Patrick Hospice House in Rock Hill. [redacted] was the first baby Hospice House had cared for. He was given Morphine for pain. According to attending MD Amy Robbins, after twenty-four hours there, [redacted] began making a sucking motion, which he had not done since his injury. The family decided to give him nutrition - Pediatyte and formula. [redacted] began acting more like a normal baby, even crying and fussing if he had a messy diaper. On January 22, [redacted] took a bottle, the family rescinded his DNR and asked that it be destroyed, and plans were initiated to transfer [redacted] to a rehabilitation facility/center.

DSS-YS 0072

On January 25, the Williams drove [redacted] back to Levine. Simple, normal four month-old tasks had to be relearned, and [redacted] underwent daily physical therapy and staff worked with him on motor skills and coordination. All of Ms. Lythgoe's visitation was to be supervised by her mother. On January 27, DSS received a report that while in Ms. Lythgoe's presence, Mrs. Williams was rocking and feeding [redacted]. She lost her balance, the chair fell out from under her and she fell on the floor. [redacted], who was on her shoulder, hit his head against the wall, leaving a red mark. Staff believed "the story does seem a bit odd". Consequently, mother and grandmother's visitation with [redacted] was to be supervised 24/7. On the 28th, both grandparents requested [redacted] be discharged soon so they could continue therapy at their home; Dr. Wunderlich examined [redacted] with a resident; and both had "concerns with family's ability to provide a safe discharge for [redacted] at this point in time". Dr. Wunderlich's 29th note reads: "At this time, I have concerns with return to maternal grandmother's home secondary to the incident. I believe foster family placement would be a safer option."

Per hospital records, at some point, visitation by both Mr. and Mrs. Williams was required to be supervised 24/7. Per *The Herald*, they started the [redacted] Foundation to help raise money for [redacted]'s rehabilitation, raise awareness of Shaken Baby Syndrome and educate other teen parents.

On February 4, DSS indicated both of [redacted]'s parents for Physical Abuse. They also recommended their placement on the Statewide Central Registry of Child Abuse and Neglect. Also that month, The Honorable Henry T. Woods presided at a closed hearing regarding how [redacted] should be fed. Ms. Lythgoe wanted him to be able to survive without invasive measures, such as a gastrostomy tube, and stated she felt that "if he could do it on his own, then it was 'God's will' for him to live". While Levine worked with Ms. Lythgoe to return [redacted] to her care, she became very distraught and stated she did not think she would be able to care for him. DSS noted she had failed twice to keep [redacted] safe from violence that caused acute and chronic brain injuries from non-accidental trauma and did not demonstrate capacity, ability or judgment to safely care for him on an inpatient unit. The only relative she agreed to for placement was her mother, who was excluded due to her criminal record. Thus, on February 17, DSS filed a Complaint and received custody via an *Ex-parte* Order.

On February 17, Levine wrote that referrals had been made to BabyNet, Interim Home Health and Advanced Home Health. Nutrition was to be supplied by WIC, which Ms. Lythgoe was to recertify. The letter delineated numerous services, visits, meetings, training and care necessary for [redacted]

On February 18, less than a month after life support was ceased, Levine discharged [redacted]. Mrs. Williams' incident with the rocker led to her care of [redacted] being questioned and her visitation being prohibited as of February 18. [redacted] was placed in a therapeutic foster home in Lancaster County. The foster mother, a Licensed Practical Nurse, works weekends. One parent is always present, and their eleven and fourteen year-old daughters are in the home. [redacted] has mobility, sight and hearing impairments, permanency as yet unknown, and receives on-site speech, occupational and physical therapy. He has a gastrostomy tube for intermittent feedings, takes medications to control seizure activity and needs early intervention, many medical procedures and close observation at all times. Medical providers have are uncertain whether he will be blind or paralyzed for the rest of his life.

The Special Conditions of Bond Order, signed March 13, shows Mr. Carduff charged with Inflicting Great Bodily Harm Upon A Child and restrained from any contact with Ms. Lythgoe and [redacted]. He was denied bond and remains incarcerated at Moss Justice Center.

Law enforcement has not charged Ms. Lythgoe. She wants custody of [redacted]. She has a full-time job and housing and has cooperated with DSS. She goes to [redacted]'s foster home for all visitation, which must be supervised, and joins his foster parents on his appointments.

Mr. and Mrs. Williams appear to have significant influence on Ms. Lythgoe, and she continually shifted care of Owen and all of her medical decisions to her mother. Guardian *ad Litem* McCauley wrote, "Having observed an interaction with Kayla and her mother at a Treatment Plan Meeting, where Owen was brought by the foster parents, I have concerns about their comprehension of the physical needs of this baby....The gastrostomy tube concerns them. They appear afraid of it. Kayla did not keep herself abreast of paperwork for Owen and his Medicaid was terminated. I believe it will take intense training and a maturity that has not been demonstrated by Kayla to be able to manage the day to day care of Owen. She has to support herself, which requires her to work and Owen should not go to a daycare setting. Mrs. Williams does not meet the requirements to be awarded custody of Owen due to a charge that was brought against her, less than 5 years ago. She would like to take care of Owen as well, but the rocking chair incident, although accidental, is an example of the lack of understanding of how inattention to detail could be detrimental to Owen's well being."

CLINICAL INTERVIEW AND BEHAVIORAL OBSERVATIONS:

Ms. Lythgoe was accompanied to the office by her mother, Charlotte Williams, and arrived on time for her evaluation appointment. She was sensibly and comfortably attired for the occasion.

Ms. Lythgoe was oriented to time, place and person. She denied any current problems or difficulties with headaches, dizziness, blurred vision, anxiety, depression, hallucinations, nightmares, sleep onset and sleep interruption. She stated she is maintained on no medication. She stated that she has never seen a psychologist, psychiatrist or mental health worker, and made it very clear that she does not believe that she needs to.

According to Ms. Lythgoe, she took her first drink at age sixteen. She reported her maximum tolerance within a twenty-four hour interval is two beers. She stated she typically does not consume alcohol, and her most recent use was at age sixteen. As concerns use of any illegal or non-prescribed drugs, she stated that she has used Marijuana on one occasion.

Ms. Lythgoe reported that she completed tenth grade. During eleventh grade, she quit school. She stated she had been maintaining a long-distance relationship with Mike Carduff, and went to live with him and his parents in Concord "because I had a bad home life".

At the present time, Ms. Lythgoe continues to reside at [redacted] in Rock Hill, S.C.. She reported that as of this July, she will have been employed with Walgreen's for two years.

When I had inquired of Ms. Lythgoe regarding her understanding of why she was here, she replied simply, "Procedure". Asked what she meant by that, she responded, "If I'm still fit after all I have been through". As there appeared to be a good deal of denial in regard to the seriousness of her present circumstances, I asked if there were any charges against her. She finally responded, "Yes. Neglect." I asked what that meant, and she replied, "I don't really think it was neglect."

Michael Carduff, father of Owen, stands charged with Unlawful Contact Toward A Child and has admitted shaking their infant out of frustration. I inquired regarding their relationship. Ms. Lythgoe stated she and Mr. Carduff have been together two years and never married "because of money". She indicated they engaged in verbal arguments about once every two weeks and had never had a physical altercation. She stated Mr. Carduff had never used alcohol or drugs and was "against it". She added, "He played videos too much and wouldn't go to bed with me". As concerns employment, she stated he began working at Food Lion in February of 2009, but in December had simply "stopped going". She stated there is "no chance" of them reconciling.

Ms. Lythgoe stated that seven month-old [redacted] has been in foster care since February. I inquired regarding Mr. Carduff's relationship with their infant. Ms. Lythgoe responded that when [redacted] cried, "I checked for the basics: diaper, feeding, rocking him to sleep. At times, I left the room until he 'cried it out'." As she had not answered regarding Mr. Carduff, I inquired again. Ms. Lythgoe responded, "He did the same". I asked whether Mr. Carduff ever became frustrated. She replied, "When he did, he would give the child to me". She spontaneously added, "I had kicked him out because he quit his job New Year's Eve, and I told him that he could not come back 'until you're not such a bum and play video games all day'." She evidenced no insight into the fact that she allowed him to return before he secured a job, and my belief is that he was still exhibiting the same irresponsible behavior.

I asked Ms. Lythgoe if she believed Mr. Carduff had injured [redacted] on more than one occasion. She replied, "I do believe it happened one time. No; something happened in December. In December, [redacted] was taken to the hospital, passed out and bleeding in his brain. I was never told that it was Shaken Baby Syndrome. In January, it happened again. DSS was involved both times, and after the first one, they suggested parenting classes". She could offer no rational explanation as to why she had not sought medical attention after she saw the bruise on [redacted]'s head on January 9 or how he sustained the multiple bodily bruises documented when he arrived at the hospital the next day.

Asked whether she could remember all of her early childhood, Ms. Lythgoe replied, "Yes!" Her account is remarkable. Her mother has married thrice, and she has one sibling, a brother. Her mother supervised an apartment complex and her father was employed in Maintenance. Her father physically abused her mother weekly, and she described him as "mean, careless and stupid". She stated the worst of his abuse she witnessed "was him punching her in the face". She indicated that on many occasions, she wondered why her mother remained in the marriage, considering the abuse her father inflicted. When asked whether her father was an alcoholic, Ms. Lythgoe indicated that he drank, but did not address the question of alcoholism. Upon further inquiry, she did state that he typically consumed a six-pack of beer a day, which certainly satisfies criteria for addiction. When Ms. Lythgoe was eleven years old, her parents divorced. Her mother next married a "naive, isolative and quiet" man who neglected and verbally abused "mom, not me", weekly. She denied any use of alcohol or drugs on his part. When Ms. Lythgoe was seventeen, her mother divorced again, and when she was nineteen, her remarried again. Ms. Lythgoe denied any sexual or physical abuse of herself and any nightmares during childhood. Asked again whether she felt that she had any problems or issues that needed to be addressed in therapy, she replied, "No!"

I inquired regarding what Ms. Lythgoe knew about Mr. Carduff's childhood and whether there had been any abuse. Her description of his childhood was idyllic. She stated his parents have an intact marriage and are both employed. Although Mike had two siblings, "he is the favorite of his mom, and he gets whatever he wants". He was raised in Florida, and "went to Disney World all the time". As a child, he was "into racing go-carts". When he was sixteen years old, the family moved to Concord. Mike's parents bought him a car for his birthday, constantly gave him money and when she lived with Mike in their home, there was no rent. She stated Mike's twenty year-old brother has never worked and still resides with his parents.

TESTS ADMINISTERED:

Bender Visual Motor Gestalt Test
Wide Range Achievement Test - Fourth Edition (WRAT4) (blue form)
Rotter Incomplete Sentences Blank (RISB) - Adult Form
Human Figure Drawing - Draw A Person (DAP)
Minnesota Multiphasic Personality Inventory - 2 (MMPI-2)

Ms. Lythgoe's *Bender Visual Motor Gestalt Test* reproduction indicated no significant perceptual motor pgvbroblems.

Achievement testing, utilizing the *Wide Range Achievement Test-Fourth Edition*, yielded the following scores and equivalencies:

SUBTEST/COMPOSITE	RAW SCORE	STAND. SCORE	CONFIDENCE INTERVAL (95%)	%ILE RANK	NORMAL CURVE EQUIV'T	STANINE	GRADE EQUIV'T	PERFORMANCE LEVEL
Word Reading	60	82	74-91	12th	25	3rd	6.9	below average, low
Sentence Comprehension								
Spelling								
Math Computation	36	85	76-96	16th	29	3rd	6.1	below average
Reading Composite								

The three point difference between Reading and Math Subtest Standard Scores was not at a sufficient level of statistical significance or prevalence in the standardization sample to warrant further investigation.

Significant responses Ms. Lythgoe provided to *Incomplete Sentences Blank* prompts follow, with no corrections to spelling or grammar:

I want to know why some things have to happen.
Back home when I was a Kid, things were easier [sic].
I regret not paying more attention
Men are confusing
The best thing about me is my personality.
A mother's love is the Strongest, most real love ever!
I feel fine
My greatest fear is being alone.
I can't wait to get my son [redacted] back!
My nerves are strong
I suffer when I get cut off from my family and friends.
I failed with finishing school.
My mind is full of thoughts.
I need to move, I fidget a lot [sic]. Always have.
Marriage is something I look forward to.
What pains me is to see people treated unfairly.
This pace is boring.
I am very upbeat.
The only trouble I have with myself is weight loss.
I wish that I could have finished School.
My father is dead to me.
I secretly want to live with my mom forever.
My greatest worry is never getting [redacted] back.
Most women are smart!

Ms. Lythgoe's *Minnesota Multiphasic Personality Inventory-2* produced a valid profile. These patients tend to be somewhat defensive. They are probably reluctant to admit problems in some areas, but willing to admit problems in other areas. Further interpretation of Ms. Lythgoe's *MMPI-2*, with changes based on results of her clinical interview and projective testing, follows:

These are typically gregarious, outgoing, sociable individuals with good social techniques. Although they need to be with others, relationships are apt to be superficial and insincere. They tend to overreact to social stimuli and be argumentative and may provoke resentment and hostility in others. Others may see them as difficult to deal with, over-reactive and prone to misperceive social stimuli. They may also be perceived as aloof and uninvolved.

Such scores indicate a verbally expressive individual who may under-control emotions. Prominent feelings probably include hostility and resentment, and family members are likely to be the focus of at least a part of these feelings. Feelings may be directly stated or expressed passive-aggressively.

Such scores may indicate a competitive, flighty, immature, opportunistic, verbally fluent individual. Exhibitionism and self-indulgence can be present. Difficulty delaying gratification and impulse control problems are possible. These people may be guarded, stubborn and touchy and overreact to criticism. Paranoid traits may include over-sensitivity and rigidity.

Similar people may think differently and have unique views about the world. Their thoughts may be creative, avant-garde and imaginative, but excessive daydreaming and avoidance of reality through fantasy are possible. Abstract interests and neglect of people and practical matters are conceivable. They can be self-critical and dissatisfied and worry about minor problems and meeting responsibilities. Feelings of being mistreated and suspiciousness may be apparent. These patients can hold on to minor hurts, harbor grudges, blame others for problems and emphasize their rational side. Projection, rationalization and intellectualization may be used excessively. Schizoid processes may be present. A thought disorder and paranoid features are possible.

These patients will not like to discuss their problems. Rapport may be difficult to establish, and this could be due to their suspiciousness and oversensitivity. Others may be seen as the cause of problems. Early termination of therapy is typical. Prognostic indication is poor.

DSM-IV DIAGNOSTIC IMPRESSION:

AXIS I:	309.4	Adjustment Disorder With Mixed Disturbance of Emotions And Conduct
AXIS II:	301.6	Dependent Personality Disorder
AXIS IV:		Severe Stressors due to DSS and legal involvement

CLINICAL FINDINGS AND CONCLUSIONS:

Even though I am not at all sure that there is not more Ms. Lythgoe could have reported regarding her childhood, many of her present issues appear to have originated in her family of origin, which she indicated she attempted to escape when she moved out of her home and in with Mr. Carduff and his family. Medical University of South Carolina's Criminal Violence Research Center indicates that witnessing abuse of a significant other during formative years often creates the physiological reaction of Posttraumatic Stress Disorder, and this may well have resulted in "hysterical blindness" in regard to Mr. Carduff.

Ms. Lythgoe clearly has no insight in regard to her issues, which are important for her to understand. Her long-standing defense mechanisms serve to protect her from identifying her own role in matters, as well as her finding of Neglect. She very much tended to deny and minimize problems in her and paramour's relationship. She does not understand the irresponsibility of her father and same irresponsibility in Mr. Carduff. In all likelihood, her tremendous blindside in regard to men is modeled after her mother. She very well may also be emotionally enmeshed with and excessively dependent on her mother due to a trauma bond.

Whether Ms. Lythgoe reconciles with Mr. Carduff or not, she still poses a threat to [redacted] until she understands her issues and failure to protect. At this time, she has no understanding of these and does not believe neglect was involved.

One Clinical Scale on Ms. Lythgoe's *MMPI-2* fell within hospitalized psychiatric range. Records convey when [redacted] was inpatient at Levine's rehabilitation unit, she failed to demonstrate capacity, ability or judgment to safely care for him and became very distraught and said she did not think she would be able to care for him. [redacted]'s Guardian expressed concerns about her and her mother's comprehension of [redacted]'s physical needs and Ms. Lythgoe's maturity, failure to keep [redacted]'s Medicaid current, and ability to manage his day-to-day care. [redacted] is a Special Needs child. All of these factors, in addition to Ms. Lythgoe's dependency and other unresolved issues, indicate a very poor prognosis for parenting.

Despite the fact that Ms. Lythgoe does not believe she has any problems and any need for therapy, her resolution of excessive dependency and issues with men is extremely important and best dealt with in therapy.

I would recommend that Mr. Carduff be evaluated and results of this evaluation be forwarded to his evaluator, as this information may have a bearing on his evaluation.

J. Patrick Goldsmith, Ed.D.
Licensed Counseling Psychologist, APA Division 17
South Carolina License #262
Fellow, American College of Forensic Examiners
Diplomate, American Board of Psychological Specialties,
Forensic Psychology

EXHIBIT

"14"

reporter that [redacted] was doing well at Levine's Children's Hospital and the baby is no longer at Hospice-she informed the reporter they gave the baby some sugar water and the baby begin to suck the bottle and move. Detective Carter eventually came from the back and asked Case manager and Kayla to come to the back to the conference room. While in the conference room Detective Carter informed Kayla that she and case manager Hill wanted to follow up with her. Detective Carter and Case manager spoke with Kayla about the recent incident with Charlotte rocking [redacted] and flipping over in the rocking chair. Kayla said she was asleep on the couch when it happened. She said her mother was feeding [redacted] and the chair fell over and she got up from the noise of the chair. She said her mother did not go get the nurse because she was still in the rocking chair and [redacted] had bumped his head. Kayla informed both that her mother told her to get a nurse. When she came into the room her mother was already standing up and they did a CT scan on [redacted] in which everything was fine with him. Incident that occurred with the shaking-Kayla said Sunday morning the family went to Church and [redacted] was fine and he did not have any bruises and nothing was wrong with him. She stated she went to her mother's home around 1-1:30pm she could not remember the exact time. She stated because she had to be at work at 2:30pm. She stated she left [redacted] with his father and around 10:30pm-he was not at home. She stated Michael usually take the baby for a drive however they did not come back for two hours. She stated she called and he told her that he was at McDonalds and [redacted] was sleep in his car seat. Kayla stated she glanced in at the baby that night however did not really check on the baby. She stated that morning the baby was crying and Michael told her that he will get the baby and she went to the restroom. She stated it was around 4am that morning. On Monday morning around 10 something-the baby was making noises and twitching-Michael was freaking out and she saw bruise on his chest-she thought that the baby may have scratched himself-they took the baby to Piedmont Medical Center because they were afraid it would take a long time for the ambulance to get to the home. Kayla talked about the baby having seizures and them transporting the baby to Levine's Children's Hospital. Case manager inquired about the scratches on his chest-she stated sometimes the baby pinches himself at night time. She stated there were no other marks/bruises on the child-she stated [redacted] scratched himself. December incident-Kayla stated she does not know what happened to the baby in December. Kayla stated she came home one day and Michael ran out the home holding [redacted] Michael told her [redacted] was asleep for a long time and he woke [redacted] up to feed him however the baby would not eat and the baby woke up screaming and went limb. She stated they took the baby to the hospital. Case manager inquired about caregiver for the child-she stated that her mother Charlotte watched the baby all the time usually 5-6 times a week. She stated they were responsible when they watched the baby-she stated somebody always watched the baby. Case manager inquired again about any marks-including the mark that her mother observed on the baby's head in November-Kayla stated Michael said he hit himself with some keys (toy) it was on a Saturday and both she and her mother was upset about the incident. She was upset at her mother for asking her questions about the baby having scratches and marks when she did not know where they were coming from. Case manager inquired about any other marks and bruises-Kayla said no. Michael leaving the home-Kayla stated she and Michael had an argument and he left the home for about a week or four days she could not remember-she stated she kicked him out around New Years Eve and he came back on the 4th or 5th of January. She stated the argument was about him not being responsible and caring for the baby and not having a job in which he quit his job. Michael's interaction/concerns: Kayla stated Michael had not done anything to make her think that he had done anything wrong to the baby and he was never violent. She stated her mother never liked Michael because of the way he looked and he was a lazy kid and felt she could do better. She stated her mother Charlotte always disagreed with Michael. Case manager inquired about Investigation-Kayla stated she thought the investigation was closed. Case manager inquired about who told her that-she stated nobody-Case manager asked her about the conversation at the home and asked her about the booklet and brochure-she stated she remember it however she forgot all about it and did not think no more about it. She stated she felt if they were parenting classes she feel as though Michael would not have done what he done. Case manager asked her who told her about parenting classes-she stated the hospital told her then she later said DSS told her about the parenting classes. She stated she though it was over and it was closed and opened up again after the incident happened again. She stated her mother has been talking to the doctors and nurses and she don't know what is going on with [redacted] She stated Case manager would need to talk to her mother about it. She stated she does not remember anything. Discipline-Kayla stated when the baby cries they usually try feeding, swing, holding and rocking the baby. She stated when she becomes frustrated she calls her mother to get the baby. Supervision/Caregivers: Case manager inquired about caregivers for the baby-Kayla mentioned her mother, Michael, and herself were the main people that watched the child. Case manager inquired about the paternal grandparents-Kayla stated they were never alone with the baby and the last time they seen the baby was for Christmas. She stated Brain would never be with the baby-she stated he was always with one of them.

Actions:

Staffing

EXHIBIT

"15"

0001545398 - [redacted] - 09/09/2009 (E)

Action Date: 2/4/2010 **Action Time:** **Time Spent:** 2.25

Input Date: 2/9/2010 **Input Time:** 12:09 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:09:54 2/9/2010

Case staffed with Supervisor Hinnant, PC Ward, Attorney Simpson, Director Stewart, PC Wallace and CM Hill for case decision. See DSS Form 3062 in file.

Actions:

Face to Face with child/client

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001545398 [redacted] /09/2009 (E)

Action Date: 2/4/2010 **Action Time:** **Time Spent:** 1.00

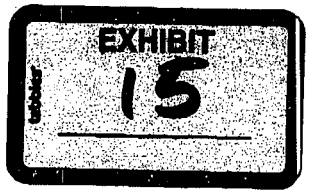
Input Date: 2/16/2010 **Input Time:** 12:19 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:19:53 2/16/2010

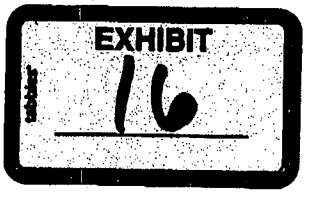
INVESTIGATIVE ASSESSMENT SUMMARY – SIX QUESTIONS: 1. Maltreatment: What is the extent of the maltreatment? R/S two month old male baby has two subdural hematoma(sizes 3mm and 2mm). R/S there is a Fatz Subdural Hematoma which raises the possibly of no accidental trauma. R/S parents behavior has been appropriate with the child. Baby is 2 months old-birthday [redacted] baby was initially admitted to Piedmont Medical on 12/4/09 and was transferred to CMC Main(Levine Hospital). R/S CT scan shows two subdural hematoma. No other children in the home. CM was informed of no physical /mental delinquency. Parents were observed to be appropriate and concerned. Parents took the baby for medical treatment on 11/28, 12/2 and 12/4. no mental/physical/spouse abuse known at this time. No known prior CPS history. Parents reside with maternal grandmother and they all are the primary caregiver of the child. Both parents are employed and live together, No known martial/financial problems or violence noted at this time. Interview with Kayla: Ms. Lythgoe said that they first noticed a change in [redacted]s behavior on 11/28/09. Ms. Carduff said that [redacted] was sleeping a lot and screamed when awake, non stop. Ms. Lythgoe said that they took [redacted] to Riverview 24hr Clinic that same evening that the doctor said nothing was wrong with him. Ms. Lythgoe said [redacted] continued this abnormal behavior throughout the week and on 12/1/09 went all day and night without urinating. (Mr. Carduff entered the room and sat by Ms. Lythgoe) Ms. Lythgoe



EXHIBIT

"16"

said they scheduled an appt with his pediatrician for 12/2/09 at Sunshine Pediatrics with Dr. Paxtor. Ms. Lythgoe said that Dr. Paxtor said that [redacted] had a throat infection and a minor cold. Dr. Paxtor did not prescribe any medication. On 12/4/09 Ms. Lythgoe said she was pulling in the driveway and Michael came outside and said that [redacted] just went limp, but was still breathing and they rushed [redacted] to Piedmont Medical Center. Upon arriving at PMC, Ms. Lythgoe said [redacted] let out a loud scream and took a huge breath. Ms. Lythgoe said PMC transferred [redacted] to Levine Hospital on 12/5/09. Collateral Contact: Laura Newmark(Social Worker)She stated that she has talked with the pediatric staff and at this time the hospital cannot determine whether the injuries are accidental or nonaccidental. She stated that [redacted]s Eye Exam and Skeletal Survey were negative. She stated that they are going to repeat the CT scan today because [redacted]s head still appears swollen. She stated that the family has no clear history of trauma, however, the hospital still cannot rule out any trauma. She stated that they parents are too young parents and the hospital mostly has concerns for lack of supervision. She stated that it is unknown if [redacted] will be discharged today or tomorrow and that will be determined by the results of [redacted]'s CT Scan. Laura stated at this point there are no obvious findings of abuse/neglect. FYI: owen is in the hospital, seizing, has an acute bleed in head, more that one bleed, multiple bruises chest, arm cheek, leg, detective carter at hospital, [redacted]s actively seizing not a good sign, he is incubated icu on a ventilator, critical condition, parents and grandparents there, parents report no knowledge of injuries and bruises, much more serious this time the injuries. Mrs. Williams reported in November she observed the child to have a bruise on his head-she stated she took a picture of the bruise-Michael and Brian had the child and could not tell her how the child got the bruise on the child's head. The week prior to December 4, 2009 the child was crying a lot and the parents took the child to Sunshine Pediatrics and they informed the parents the child had a throat infection and it had gotten worse-child was taken to Riverview Medical Center and later taken to Piedmont Medical Center in which they performed test-Michael was watching the child when the baby went limb-Kayla had gotten off from work and Michael meet her at the door with the baby limb scratched out. Child was taken to Piedmont Medical Center then Levine's. It was determined the baby had bruising to the brain. Mrs. Williams stated there were no other incidents she could recall after wards until this weekend. [redacted] was at her home on Saturday and she observed looked like to be a scratch on the child's head-she placed the child in the light and observed a bruise about the size of a dime on the child's forehead. She stated she felt it and it was soft and full-she stated she observed the nurses and doctors last time checking the child like that. Michael was asked about the child's forehead in which he stated he did not know. He later stated the child sleeps in the crib by himself and he maybe hit his head on something. On Sunday, during child the child was sitting on Michael's lap and later placed in his carrier. When asked to hold the child-Michael would not allow her-When asked to have the child come to her home-Michael stated the baby was going home with them. 2. Nature: What surrounding circumstances accompany the maltreatment? Family did not have any prior DSS history 3. Child Functioning: How does the child function on a daily basis? Include pervasive behaviors, feelings, intellect, physical capacity and temperament. There is one minor child of the family. [redacted] was born September 9, 2009-child did not attend daycare-child was taken care of by his parents and grandmother Charlotte Williams. Child did not have any outside services. Owen received medical service from Sunshine Pediatrics, Piedmont Medical Center, Levine's Children's Hospital, and Riverview Medical Center. [redacted] is currently at Levine's Children's Hospital he recently received the G-tube surgery-he was having a hard time feeding and was not getting enough calories-family were in argument with the surgery however changed their mind-in the end Kayla signed the consent to have the surgery. 4. Parenting – Discipline: What are the disciplinary approaches used by the parent and under what circumstances? Parents stated during follow up they do not discipline the child-later it was discovered/disclosed that Michael shook the baby because the baby would not stop crying and he was frustrated with the baby-he stated when the baby cries they usually take the baby for a ride in the car or take the baby to the Williams' home. While in the hospital in January-[redacted] had marks and bruises on his body. 5. Parenting – General: What are the overall, typical, pervasive parenting practices used by the parent? (Do not include discipline.) The family did not have any expectations for the baby-When there was a problem Kayla usually calls her mother and her mother helps with [redacted]n which [redacted] would visit her home everyday when both Kayla and Michael worked. 6. Adult Functioning: How does the adult function with respect to daily life management and general adaptation? What mental health functioning and/or substance use is apparent on a daily basis? Both parents were working-Kayla is employed with Wal-greens and Michael was employed at Food Lion however he quit and now is incarcerated with Criminal History-Civil Disturbance-February 13, 2009-R/S responded to above listed incident location in reference to a civil disturbance. Upon arrival R/S spoke with Josiah who stated that while hanging out in his room, Bagley sat on him at which time he pushed out and then Bagley knocked him off the bed. Bagley was then pushed out of the house by Josiah at which time he starting making comments about wanting to beat up. Caleb then stated that Bagley made comments that if he was not beat up that he was going home and get a gun and shoot himself. R/S then spoke with Bagley who stated that he made the comments, but that the was wanting Josiah and Caleb to let him back in the house. R/S also spoke with Bagley's parents and advised them of the incident. Nothing further at time of report. There are some concerns for Charlotte Williams-she have several last names-Charlotte Lythgoe,



HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Face to Face with child/client

Staffing

Recipients:

0001545390 - Lythgoe, Kayla - [redacted]

0001556202 - Williams, larry - [redacted]

Action Date: 2/2/2010	**Action Time:** 1:30 PM	**Time Spent:**	2.25
Input Date: 2/17/2010	**Input Time:** 9:16 PM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

PM 9:16:21 2/17/2010

Face to Face with Child/Client-2/2/2010

MDT Meeting at Levine's Children's Hospital 1:30pm

Present at the MDT Meeting were:

DSS agency David Simpson, Yvonne Stewart, Phyllis Ward, Krista Hinnant, and Dirvondra Hill.

Law Enforcement-Detective Division(York County) Detective Amanda Carter and WJ Miller

Levine's Children's Hospital: Social Worker Linda Brown, Dr. Colleen Wunderlick, Nurse Saer, Occupational therapist, and physical therapist.

The agency was informed that [redacted] was not able to take in enough calories by mouth and can not swallow and can not do it. The family is under the impression that the baby is doing well however the baby is not and the baby will need a G-tube placement to help him to be able to take in enough calories. This is not uncommon for babies that sustain a brain injury. [redacted]'s sucking has regressed. If this family agrees to the g-tube placement the discharge would be pushed back to make sure there are no problems and to monitor. The recovery curve would be three months in which there will not be a lot of change after that. [redacted] will need lots of services for his condition. The agency was informed about the interaction between [redacted] and Kyla-the hospital informed the agency the interaction/bonding is minimum and Kayla is really not involved-she usually is seen sleeping a lot of the time. The Grandmother Charlotte is the one that is involved. Kayla does not really ask questions she plays with the toys during the therapy.

The family was brought into the meeting later-We were informed that Charlotte had to go home because she was not feeling well. Present from the family was Larry and Kayla. The doctor informed both Kayla

SCDSS 0242

and Larry about the recommendations for [redacted] Larry had some questions for the doctors and stated whatever was best for [redacted] is what they wanted.

Medical staff spoke about [redacted] being very disorganized and can't get the milk out of the bottle. The nurses have been working with [redacted] to measure how much calories he is taking in. There was some questions about what the family plan was before he went to hospice-they spoke about families never requested to withdraw nutrition in which they did withdrawn all care including nutrition from [redacted] does not have state regulation in which he just cries and screams all the time. [redacted] has extensive brain damage-he sees bright lights however unknown at this time if he can see. The medical staff informed the agency if we were going to bring the child into placement the foster parent would need 5 days. At this time [redacted]'s medication has changed-he is taking seizure medication and another medication to help him. The occupational therapist stated a hearing test was performed and an eye to voice-however the child is not making much process. [redacted] will have a disability and require long term care. He has a problem with the reflex of tone and it does not connect-The family needs to understand these things. They have to be willing to take what they can get and work with the child.

Actions:

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla - [redacted]

Action Date:	2/2/2010	**Action Time:**		**Time Spent:**	0.25
Input Date:	2/16/2010	**Input Time:**	11:24 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:24:36 2/16/2010

Protective Capacity Assessment Summary:
Kayla Lythgoe is the mother to [redacted]. Kayla could not determine what happened to [redacted] in December-Owen has had several bruises on him and Kayla never paid attention to the marks. Kayla depends on her mother to make decisions for the child. Kayla appears immature-she does not bond with [redacted] and usually sleeps the entire time. Kayla stated that case manager needed to speak with her mother about [redacted]'s condition.

Actions:

Face to Face with child/client

Recipients:

0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted]

Action Date:	2/2/2010	**Action Time:**		**Time Spent:**	0.25
Input Date:	2/16/2010	**Input Time:**	11:31 AM	**Worker:**	Hill, Dirvondra

EXHIBIT

"17"

about a sitter for the family and informed the family about safety plan due to the incident that occurred. Case manager was informed they don't have sitter's on the 4th floor for rehab. Case manager informed them that Charlotte has been the only person caring for the child because her husband works and they have other children, Kayla is back and forth and she usually does not bond with the child. Carol stated she noticed that the Grandmother is the only person that is there always with the child. She stated she would see what she can do about the sitter. She stated however there is usually 2 people in the room that would be the sitter and the other person-she stated this is not a 24/7 thing-she stated the sitter is usually 12 hours and they pick what they want-either the 7am-7pm or the 7pm-7am. She stated they are gonna have to understand that. She stated she feels as though the child needs to be placed in foster care and the foster parent needed to be the one at the hospital instead of the family. Case manager arrived back in the room and followed up with the family-Charlotte stated-you see what Im talking about with that rocking chair. Case manager informed Charlotte that she did test the rocking chair and the only way the rocking chair could have been flipped over if she was rocking really hard in it. Charlotte stated she was not rocking hard in the rocking chair and she was rocking at a normal pace with the child. Case manger informed them again of the safety plan and information about the sitter. Charlotte begins to yell and talk in a rage at case manager. Case manager informed Charlotte they usually don't provide a sitter for this floor-Charlotte rolled her eyes at case manager. Case manager observed the physical therapist working with [redacted] cried and appeared not to be engaged in the activity.

Actions:

Telephone Contact

Recipients:

0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001545398 - [redacted] 09/2009 (E)

Action Date:	1/27/2010	**Action Time:**	10:10 AM	**Time Spent:**	0.25
Input Date:	1/27/2010	**Input Time:**	8:47 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 8:47:02 1/27/2010

Supervisor contacted Lt. Miller in regards to the incident that occurred with Charlotte falling out of rocking chair with [redacted] hitting his head. Lt. Miller stated that Detective Carter would go to hospital to follow up. Supervisor informed Lt. that CM Hill was on her way to the hospital as well.

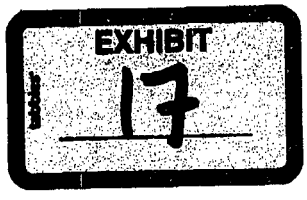
Actions:

Collateral Contact
Telephone Contact

Recipients:

0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545398 - [redacted] - 09/09/2009 (E)

Action Date:	1/27/2010	**Action Time:**	9:30 AM	**Time Spent:**	0.50
Input Date:	1/28/2010	**Input Time:**	5:12 PM	**Worker:**	Hill, Dirvondra



EXHIBIT

"18"

reporter that [redacted] was doing well at Levine's Children's Hospital and the baby is no longer at Hospice-she informed the reporter they gave the baby some sugar water and the baby begin to suck the bottle and move. Detective Carter eventually came from the back and asked Case manager and Kayla to come to the back to the conference room. While in the conference room Detective Carter informed Kayla that she and case manager Hill wanted to follow up with her. Detective Carter and Case manager spoke with Kayla about the recent incident with Charlotte rocking [redacted] and flipping over in the rocking chair. Kayla said she was asleep on the couch when it happened. She said her mother was feeding [redacted] and the chair fell over and she got up from the noise of the chair. She said her mother did not go get the nurse because she was still in the rocking chair and [redacted] had bumped his head. Kayla informed both that her mother told her to get a nurse. When she came into the room her mother was already standing up and they did a CT scan on [redacted] in which everything was fine with him. Incident that occurred with the shaking-Kayla said Sunday morning the family went to Church and [redacted] was fine and he did not have any bruises and nothing was wrong with him. She stated she went to her mother's home around 1-1:30pm she could not remember the exact time. She stated because she had to be at work at 2:30pm. She stated she left [redacted] with his father and around 10:30pm-he was not at home. She stated Michael usually take the baby for a drive however they did not come back for two hours. She stated she called and he told her that he was at McDonalds and [redacted] was sleep in his car seat. Kayla stated she glanced in at the baby that night however did not really check on the baby. She stated that morning the baby was crying and Michael told her that he will get the baby and she went to the restroom. She stated it was around 4am that morning. On Monday morning around 10 something-the baby was making noises and twitching-Michael was freaking out and she saw bruise on his chest-she thought that the baby may have scratched himself-they took the baby to Piedmont Medical Center because they were afraid it would take a long time for the ambulance to get to the home. Kayla talked about the baby having seizures and them transporting the baby to Levine's Children's Hospital. Case manager inquired about the scratches on his chest-she stated sometimes the baby pinches himself at night time. She stated there were no other marks/bruises on the child-she stated [redacted] scratched himself. December incident-Kayla stated she does not know what happened to the baby in December. Kayla stated she came home one day and Michael ran out the home holding [redacted] Michael told her [redacted] was asleep for a long time and he woke [redacted] up to feed him however the baby would not eat and the baby woke up screaming and went limb. She stated they took the baby to the hospital. Case manager inquired about caregiver for the child-she stated that her mother Charlotte watched the baby all the time usually 5-6 times a week. She stated they were responsible when they watched the baby-she stated somebody always watched the baby. Case manager inquired again about any marks-including the mark that her mother observed on the baby's head in November-Kayla stated Michael said he hit himself with some keys (toy) it was on a Saturday and both she and her mother was upset about the incident. She was upset at her mother for asking her questions about the baby having scratches and marks when she did not know where they were coming from. Case manager inquired about any other marks and bruises-Kayla said no. Michael leaving the home-Kayla stated she and Michael had an argument and he left the home for about a week or four days she could not remember-she stated she kicked him out around New Years Eve and he came back on the 4th or 5th of January. She stated the argument was about him not being responsible and caring for the baby and not having a job in which he quit his job. Michael's interaction/concerns: Kayla stated Michael had not done anything to make her think that he had done anything wrong to the baby and he was never violent. She stated her mother never liked Michael because of the way he looked and he was a lazy kid and felt she could do better. She stated her mother Charlotte always disagreed with Michael. Case manager inquired about Investigation-Kayla stated she thought the investigation was closed. Case manager inquired about who told her that-she stated nobody-Case manager asked her about the conversation at the home and asked her about the booklet and brochure-she stated she remember it however she forgot all about it and did not think no more about it. She stated she felt if they were parenting classes she feel as though Michael would not have done what he done. Case manager asked her who told her about parenting classes-she stated the hospital told her then she later said DSS told her about the parenting classes. She stated she though it was over and it was closed and opened up again after the incident happened again. She stated her mother has been talking to the doctors and nurses and she don't know what is going on with [redacted] She stated Case manager would need to talk to her mother about it. She stated she does not remember anything. Discipline-Kayla stated when the baby cries they usually try feeding, swing, holding and rocking the baby. She stated when she becomes frustrated she calls her mother to get the baby. Supervision/Caregivers: Case manager inquired about caregivers for the baby-Kayla mentioned her mother, Michael, and herself were the main people that watched the child. Case manager inquired about the paternal grandparents-Kayla stated they were never alone with the baby and the last time they seen the baby was for Christmas. She stated Brain would never be with the baby-she stated he was always with one of them.

Actions:

Staffing

EXHIBIT

"19"

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 20100001027 LEAD NUMBER:

PERSON INTERVIEWED: Kayla A. Lythgoe

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER:

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29732 TELEPHONE: [redacted]

(WORK) Walgreens/ Rock Hill, SC

TELEPHONE:

DATE OF INTERVIEW: January 11, 2010 TIME:

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina (Levine)

PURPOSE/TOPIC OF INTERVIEW: Injuries to [redacted]

DETAILS OF INTERVIEW:

Kayla said that she works for Walgreens in Rock Hill, South Carolina. Kayla said that she awaken Monday morning and that she heard her baby making noise, (A whimper). Kayla said that she went into his room and that he was twitching. Kayla said that [redacted] was blinking and that his eyes were open and positioned to the side of his eyes.
Kayla said that she yelled for Michael, ([redacted] father). Kayla said that she took the blanket off of him and discovered that [redacted] had a bruise on his chest. Kayla said that she pinched [redacted] on his right arm as she was told by doctor to do the first time that [redacted] was unresponsive.Kayla said that [redacted] had on only a diaper because he sweats when he sleeps.
Kayla began to retract what happened before she discovered [redacted] twitching. Kayla said that on Sunday morning that they, she, Michael and [redacted] went to church. Kayla said that this was the last time that she saw [redacted] undressed before his injuries. Kayla said that while at church that [redacted] vomited on himself and that she changed his clothes. Kayla said this was about 11:30 or 12:00. Kayla said that her mother invited them over to eat Chili and that Michael did not want to go so she went to her mothers and that she left from her mother's home to go to work. Kayla said that she went to work around 2:30pm. Kayla said that she did text Michael throughout the day asking him how was [redacted] doing. Kayla said that Michael told her that Owen was cranky.

Kayla said that on Sunday night that she got home from work a little after 10:30pm. Kayla said that when she arrived home that Michael nor [redacted] was there. Kayla said that Michael returned to the residence about 2 hours later.
Kayla said that she did not actually see [redacted] when Michael and he arrived on Sunday Night. Kayla said that Michael was carrying [redacted] in the car seat and that he was asleep and wrapped up in a blanket. Kayla said that [redacted] does wake up during the night and that normally she is the one that gets up with him. Kayla said that however, on Monday Morning around 4:00 am that she awaken, got up and went to the bathroom and that she intended to go in and check [redacted] Kayla said that Michael got up with [redacted] which was very unusual because this was the first time he ever got up with him at night. Kayla said that she saw Michael and what she thought was him trying to give [redacted] a bottle. Kayla said that she was going to go further into the room when Michael told her, "I got it". Kayla said that she got back into bed.

Kayla said that another thing was strange. Kayla said that once I appeared to interview the family that Michael said to her, " I forgot to tell you that [redacted] did hit his head on the Rocking Chair". This was his explanation for the bruise on his head.
Kayla said that on Sunday night that she got home from work a little after 10:30pm. . Kayla said that the week before that [redacted] did sleep alot and that she took him to Riverview. Kayla said that they told her that nothing was wrong with him. Kayla said to her he was acting strange and that she took him to his Pediatric at Sunshine.
Kayla said that his doctor said that [redacted] had a throat infection but they did not give him any medicine. Kayla said the other time that she was at work and that when she pulled in the driveway that Michael ran outside with [redacted] saying that he was cranky. She said Michael said he woke him up for a bottle and [redacted] did not eat. Kayla said [redacted] screamed and passed out. Kayla said he just went limp. Kayla said, "sometimes, Michael picks up [redacted] to quick or handle him to rough, I have to tell him to be easy". Kayla said , "I don't think Michael would intentionally do anything but they say it is Shaken Baby Syndrome". Kayla said that she had just let Michael move back in. Kayla said that she put him out because he lost his job because he wouldn't go to work and that she told him he had to work.

OFFICER / AGENT: Amanda P. Carter

PAGE 1 OF 1

EXHIBIT 19 446

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 201000001027 LEAD NUMBER:

PERSON INTERVIEWED: Kayla A. Lythgoe

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER:

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29732 TELEPHONE: [redacted]

(WORK) Walgreens/ Rock Hill, SC

TELEPHONE:

DATE OF INTERVIEW: January 28, 2010 TIME:

LOCATION OF INTERVIEW: Moss Justice Center

PURPOSE/TOPIC OF INTERVIEW: Injuries to [redacted]

DETAILS OF INTERVIEW:

*This interview was scheduled before Polygraph for verification purposes

On this date Kayla was interviewed again and she was consistent with her last statement. Kayla said Sunday Morning we went to church and [redacted] was fine. He spit up and she changed his outfit. They, (she, Michael, [redacted]) went back home. She went to Moms for dinner left mother residence and went to work.

Kayla said she got home about 10:30 pm and that Michael and [redacted] was not there. Kayla said that Michael came in about 2 hours later and [redacted] was asleep. Kayla said she got up to go to restroom at approximately 4:00 am and that Michael was changing [redacted] and she looked in the room and he told her that he had it.

Kayla said that at about 10:00 am that she heard [redacted] making a squeaky noise. Kayla said that she called Michael and he came into the room. Kayla said that she uncovered [redacted] and asked Michael how [redacted] got the bruises. Kayla said that Michael told her that he didn't know. Kayla said that she thought that maybe [redacted] had scratched himself. Kayla said that they took [redacted] to Piedmont Medical Center.

Kayla said that Michael told her when he came in with [redacted] the night before that they just rode around and that he went to MacDonald's to get him something to eat.

Kayla said that she kicked Michael out of the house because they argued about him not having a job. Kayla said that she kicked him out on New Years Eve. Kayla said it was at least a week before this incident with [redacted]

Kayla said that on Saturday that her Mom saw a bruise on [redacted]'s head and asked her where did [redacted] get the bruise and that she offered to keep [redacted] because of the bump. Kayla said that Michael told her that this bump was from [redacted] playing with his plastic keys. Kayla said but at the hospital he told her that he bumped his head on the Rocking Chair.

Kayla said that on December 4, 2009 that she came home from work and that Michael ran out with [redacted] and that [redacted] was completely limp. Kayla said that Michael told her that [redacted] was asleep and that when he awaken that he tried to feed him and that [redacted] would not take his bottle. Kayla said that Michael told her that [redacted] yelled out and went limp. Kayla said that on December 5, 2009, that [redacted] was transferred to Carolina Medical. Kayla said that Michael never showed any anger toward [redacted]. Kayla said, "I did thought that it was odd that night that Michael got up with [redacted] because Michael never got up with [redacted] or helped with him unless I asked".
Kayla said that she with the help of her Mom decided to discontinue the Life Support for [redacted] Kayla said that they decided that it was not good for him to live like that.

OFFICER / AGENT: Amanda P. Carter

PAGE 1 OF 2

Kayla said that on the December 4, 2009, episode that [redacted] did not have any marks or bruises. Kayla said that he did have a bleeder in his head and that she was confused because she did not know how babies just bleed. Kayla said that one of the Nurses told her that infants could do that in the Womb.

Kayla said that the Nurse told her that there is not a cause for everything. Kayla said that the hospital did a full body scan.

Kayla said now, it seems that everything happened bad to [redacted] that he was in Michael's care. Kayla said that "I think that's kinda weird".

Kayla said that when her Mom asked about the bruise on [redacted]'s head on Saturday that she told her Mom, "don't start". Kayla said that the reason she said that was because her mother never liked Michael and that she disliked how he looked. Kayla said that her mother said that he was lazy and a kid and that she could do better.

Kayla said that "I think if we had gotten the parenting classes that this may not have happened. That we would be more educated on caring for a baby.

*Note

1/28/10

*Charlotte and [redacted] flipped Rocking Chair at Levine

Kayla said that she was asleep and that her mother was feeding [redacted] and that she woke up to a crash. Kayla said that her mother told her to get the Nurse and that she did. Kayla said that when she came back into the room that her mother and [redacted] was up off the floor.

Kayla said the chair was on the floor and that [redacted] cried.

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 20100000 LEAD NUMBER:

PERSON INTERVIEWED: Jennifer Carduff

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER:

ADDRESS: (HOME) [redacted], Concord, North Carolina

TELEPHONE: [redacted]

(WORK)

TELEPHONE:

DATE OF INTERVIEW: 1-11-10 TIME:

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina

PURPOSE/TOPIC OF INTERVIEW: Child Abuse of [redacted]

DETAILS OF INTERVIEW:

Mrs. Carduff is the Paternal Grandmother of 4 month old, [redacted]

Mrs. Carduff said that she met her son at Carolinas Medical Center after receiving a phone call that they were bring[redacted]o the hospital from Rock Hill there.

Mrs. Carduff said she does not know anything except that the last time that [redacted] was here at Carolina's that they had a team of at least 5 doctors and that they never gave an explanation as to how [redacted]s injury occurred.

Mrs. Carduff said they told them then that the injury was not severe enough to do Surgery to eliminate the pressure.
Mrs. Carduff said that there was pressure on the brain then like now and that they never got the results.

OFFICER / AGENT: Amanda P. Carter

PAGE 1 OF 1

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 2010 LEAD NUMBER:

PERSON INTERVIEWED: Charlotte Williams

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER:

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29730 TELEPHONE:

(WORK)

TELEPHONE:

DATE OF INTERVIEW: 1-11-10 TIME:

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina

PURPOSE/TOPIC OF INTERVIEW: Child Abuse of [redacted]

DETAILS OF INTERVIEW:

Mrs. Williams is the Maternal Grandmother of 4 month old victim, [redacted]
Mrs. Williams said , "I knew this was coming". Mrs. Williams said that she had her suspicions of Michael abusing the baby since November. Mrs. Williams said that in November that the baby had a bruise on his forehead and that Mike and his brother Brian had kept the baby all day. Mrs. Williams said that she told her husband that she wanted to keep the baby more because of what she suspected and that her husband told her that Michael has to become responsible.

Mrs. Williams said that she was holding [redacted] on Saturday Night and that she noticed a scratch bump and bruise on his forehead at the hair line. Mrs. Williams said she asked Michael about it and that he told her, he must have gotten the injury in the crib because he said that he leaves him in the crib by himself. Mrs. Williams said that she told him that babies scratch themselves but that this wasn't a baby scratch. Mrs. Williams said that Michael told her that he did not know what happened.

Mrs. Williams said she didn't see any other bruises on [redacted] Mrs. Williams said that Mike is rough with the baby. Mrs. Williams said that he has had to be reminded that when he picks the baby up that he needs to hold the baby's head. Mrs. Williams said that when she saw the bruises, bump and scratch that she was really upset. Mrs. Williams said that she was upset with her daughter Kayla. Mrs. Williams said that the reason that she was upset with Kayla was because she didn't like Kayla's respond of "oh, don't start that again". Mrs. Williams said that she believes that Kayla is protecting Michael. Mrs. Williams said that the last time that she saw [redacted] was Sunday Morning that the [redacted] Kayla and Michael was at church.

Mrs. Williams said that [redacted] looked fine. Mrs. Williams said after church services that she had cooked Chili and that Kayla came over for Dinner. Mrs. Williams said that she asked Kayla where was Michael and [redacted] and that Kayla told her that Ugly. Mrs. Williams said that Kayla came to her home about 1:30 pm.

Mrs. Williams said Kayla left her residence and went to work. Mrs. Williams said, "I am concern and trying to figure out, why did DSS close the 1st case so soon". Mrs. Williams said she also want to know what happened to the Parenting classes that DSS was suppose to be setting up for Michael and Kayla.

Mrs. Williams said that Michael and his brother plays Video games 24/7. Mrs. Williams said that Kayla had kicked Michael out of the house because when the last incident happened while the baby was in the hospital that Michael would not go to work and that he lost his job. Mrs. Williams said that apparently she let him back in.
Mrs. Williams said that she remembers Michael was talking baby talk to the baby over her house and that Kayla said that Michael never talks to the baby at home. Mrs. Williams said that as far as Michael rocking [redacted] in the rocking chair that she has never seen Michael rock [redacted] and she does not believe they ever use that rocker. Mrs. Williams said that he usually just stick [redacted] in his swing.

OFFICER / AGENT: Amanda P. Carter

PAGE 1 OF 1

EXHIBIT

"20"

INCIDENT INTERVIEW REPORT

YCSO CASE NUMBER: 2010 LEAD NUMBER:

PERSON INTERVIEWED: Charlotte Williams

DATE OF BIRTH: [redacted] SOCIAL SECURITY NUMBER:

ADDRESS: (HOME) [redacted]

Rock Hill, South Carolina 29730 TELEPHONE:

(WORK)

TELEPHONE:

DATE OF INTERVIEW: 1-11-10 TIME:

LOCATION OF INTERVIEW: Carolina Medical Center Main/ Charlotte North Carolina

PURPOSE/TOPIC OF INTERVIEW: Child Abuse of [redacted]

DETAILS OF INTERVIEW:

Mrs. Williams is the Maternal Grandmother of 4 month old victim, [redacted]
Mrs. Williams said , "I knew this was coming". Mrs. Williams said that she had her suspicions of Michael abusing the baby since November. Mrs. Williams said that in November that the baby had a bruise on his forehead and that Mike and his brother Brian had kept the baby all day. Mrs. Williams said that she told her husband that she wanted to keep the baby more because of what she suspected and that her husband told her that Michael has to become responsible.

Mrs. Williams said that she was holding [redacted] on Saturday Night and that she noticed a scratch bump and bruise on his forehead at the hair line. Mrs. Williams said she asked Michael about it and that he told her, he must have gotten the injury in the crib because he said that he leaves him in the crib by himself. Mrs. Williams said that she told him that babies scratch themselves but that this wasn't a baby scratch. Mrs. Williams said that Michael told her that he did not know what happened.

Mrs. Williams said she didn't see any other bruises on [redacted] Mrs. Williams said that Mike is rough with the baby. Mrs. Williams said that he has had to be reminded that when he picks the baby up that he needs to hold the baby's head. Mrs. Williams said that when she saw the bruises, bump and scratch that she was really upset. Mrs. Williams said that she was upset with her daughter Kayla. Mrs. Williams said that the reason that she was upset with Kayla was because she didn't like Kayla's respond of "oh, don't start that again". Mrs. Williams said that she believes that Kayla is protecting Michael. Mrs. Williams said that the last time that she saw Owen was Sunday Morning that they [redacted] Kayla and Michael was at church.

Mrs. Williams said that [redacted] looked fine. Mrs. Williams said after church services that she had cooked Chili and that Kayla came over for Dinner. Mrs. Williams said that she asked Kayla where was Michael and [redacted] and that Kayla told her that Ugly. Mrs. Williams said that Kayla came to her home about 1:30 pm.

Mrs. Williams said Kayla left her residence and went to work. Mrs. Williams said, "I am concern and trying to figure out, why did DSS close the 1st case so soon". Mrs. Williams said she also want to know what happened to the Parenting classes that DSS was suppose to be setting up for Michael and Kayla.

Mrs. Williams said that Michael and his brother plays Video games 24/7. Mrs. Williams said that Kayla had kicked Michael out of the house because when the last incident happened while the baby was in the hospital that Michael would not go to work and that he lost his job. Mrs. Williams said that apparently she let him back in.
Mrs. Williams said that she remembers Michael was talking baby talk to the baby over her house and that Kayla said that Michael never talks to the baby at home. Mrs. Williams said that as far as Michael rocking [redacted] in the rocking chair that she has never seen Michael rock [redacted] and she does not believe they ever use that rocker. Mrs. Williams said that he usually just stick [redacted] in his swing.

OFFICER / AGENT: Amanda P. Carter

PAGE 1 OF 1

EXHIBIT 20

EXHIBIT

"21"

about it & Kayla got defensive & they would not let her (Charlotte-gm) hold him in church or get him after church

Mr Williams is a pastor

Ophthalmologist examined baby on 7-00 pm & there was bleeding behind retina (retinal hemorrhage

mom left hospital to accompany Michael to get his polygraph & did not get back to the hospital - more worried about Michael than the baby

gm noticed a scratch on baby forehead in Nov & then noticed a bruise on forehead on Sat, 1/9

- we made LE referral after Dec incident

- MGM took picture of Nov bruise & asked Michael uncle Brian Cardiff about it & they had no idea how it occurred - Kayla had not even seen it

---

Training Issues -
developmental stage
subdural hematomas - DS

DSS-YS 0049

EXHIBIT 21 454

EXHIBIT

"22"

PM 3:01:31 1/12/2010

Supervisor contacted Lynn Myers, Child Maltreatment Coordinator at Levine Children's Hospital (704-355-4088 pager # 7814). Lynn expressed concerns that Charlotte Williams (maternal grandmother) may have known about [redacted] and him being shaken. Lynn stated that the Grandmother has told hospital staff that she has seen bruises on the child. Supervisor asked Lynn about the Grandmother having contact with the child while the child is at the hospital. Lynn stated that everyone who visits [redacted] is having supervised contact. Lynn stated that nursing staff is supervising the contact and that they have had to ask visitors to leave when nurses are unavailable to supervise. Lynn stated that [redacted]'s conditions is deteriorating. She stated that it is possible that he will not make it. Lynn stated that [redacted] was seizing this morning and that the child is going to have surgery to put a stint in to drain the blood/fluid off of his brain. Lynn stated that the mother is currently at the hospital. Supervisor provided Lynn with contact information to update Supervisor with any new information.

Actions:

Collateral Contact

Telephone Contact

Recipients:

0001545398 - Carduff, Owen - 09/09/2009 (E)

Action Date:	1/12/2010	**Action Time:**		**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	10:03 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

AM 10:03:07 1/12/2010

Collateral Contact Called Levine's Hospital to speak with Laura McDowell regarding any updates-case manager was informed that Laura was not at the desk and she would give Laura the message to call case manager back when she get off the phone-case manager inquired about the condition of the child-case manager was informed they were doing a plug on the child-case manager inquired what a plug was-she stated a plug is when they take fluid out to release the pressure in the brain.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] 09/09/2009 (E)

Action Date:	1/12/2010	**Action Time:**		**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	3:04 PM	**Worker:**	Himhant, Krista

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

EXHIBIT

"23"

Cm made telephone contact with Charlotte Williams to inform her that the home study was found to be unfavorable and [redacted] will not be placed with her. Charlotte questioned why and cm explained to her about their criminal history and the department can not place a child with someone who has criminal history. Charlotte asked if [redacted] could be placed with Michael's parents and cm explained that is a possibility but we will also have to do a homestudy on them. Charlotte then asked where [redacted] was going to go since he is being discharged today and cm explained she did not know the answer to that as of right now. Charlotte was upset about the homestudy and stated that she did not understand since her charges were misdemeanors. Charlotte wanted to know if she could fight the finding of the home study and cm stated that a court would have to over rule. Cm asked Charlotte where Kayla was because cm needed to speak with her and Charlotte stated that she was at the hospital and could be reached on her cell phone.

Actions:

Face to Face with child/client

Recipients:

0001545391 - Williams, Charlotte - 03/01/1959 (E)
0001556202 - Williams, larry - 04/02/1959 (E)

Action Date:	2/16/2010	**Action Time:**	2:15 PM	**Time Spent:**	1.00
Input Date:	2/22/2010	**Input Time:**	11:43 AM	**Worker:**	Hemphill, Diva

Service ID: 0001395295
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:43:45 2/22/2010

CW Hemphill arrived at [redacted] in Rock Hill the home of Larry and Charlotte Williams. CW informed both Mr. and Mrs. Williams of the current allegations. Charlotte spoke about the incident of her falling out of the rocking chair while holding [redacted] at the hospital. She reported that she was holding him up on her shoulder and he was sliding down towards her chest area. She reported she was burping [redacted] when the incident occurred. She reported that she was trying to slide him back up to her shoulder when she went back the chair flipped and both her and [redacted] fail out of the chair. She reported he hit is head a little and cried a little. She reported she was taking with the nurse right before the incident occurred and as soon the nurse walked out of the room that was when the rocking chair flipped. She stated that it was reported that she was going at a very high rate of speed, but she denied that she was going fast. She reported that the nurse even said she was not going fast while she was present in the room. She stated that she did not mean to flip the chair over and it happen. Mrs. William reported Kayla was in the room on the couch asleep when the incident occurred. She stated that Kayla got up as soon as the incident happen and asked if she was alright. CW addressed the concerns of Mr. Williams feeding [redacted] after the family had been informed they were not allowed to feed him only the doctors. Mr. Williams reported he never feed [redacted] at the hospital or at hospice. He stated when he realize [redacted] could eat while at hospice he did go home and get a bottle for him to drink out of, but hospice did not use the bottle nor did he. He stated hospice feed [redacted] sugar water, but deny him ever feeding [redacted] when they had been informed not to do so by nurses. Both admitted to a verbally agreement regarding [redacted] receiving a feed tube. Charlotte reported the doctors had spoken with them about putting a feeding tube in [redacted] She reported later on that same afternoon after speaking with them about the feeding tube the doctor came in for the consent to be sign and Kayla was at work. She reported she explained to the doctor that Kayla was at work and could sign the feeding tube tomorrow morning. She stated they informed her the consent had to be signed that night. She reported she contacted Kayla over the phone and Kayla gave and verbally concert over the phone. She reported through the night they talked among themselves and others and decided they did not want [redacted] to have the feeding tube. She reported that her brother is a medical doctor and he had advised them not to do so. She reported the next morning they informed the hospital that they decided not to go with the feeding tube and wanted to know if they had other choices. She reported that Kayla never did rip the consent up because she never did

EXHIBIT

"24"

Page 1

Transcript of Recordings
Labeled "Lola DSS (Part 1)"
and "Lola DSS (Part 2)"
Dated 12/17/2009
- - - - - - - - - - - - -

Transcribed by: Audrey S. Beebe,
Southern Reporting, Inc.

Page 2

LOLA: York County DSS. This is Lola. How may I help you?
LIEUTENANT MILLER: Where have you been hiding?
LOLA: 18 West Liberty Street, down the hall.
LIEUTENANT MILLER: You have?
LOLA: Yeah. How are you doing, W.J.?
LIEUTENANT MILLER: I'm doing good right this second.
LOLA: That's good.
LIEUTENANT MILLER: But is Devondra Hill still Christa Hemmett's?
LOLA: Yes, she is. And they are both not in the office.
LIEUTENANT MILLER: Oh, no shit.
LOLA: Yeah. They ran away.
LIEUTENANT MILLER: I -- sometimes I -- you know, I try not to get upset, and I --
LOLA: I know.
LIEUTENANT MILLER: -- I probably shouldn't.
LOLA: Uh-huh. You're safe.
LIEUTENANT MILLER: But why would I get a DSS report of a one-year-old child who has two subdural hematomas and a flax [sic] subdural hematoma today when it was -- the child was taken to Piedmont on December the 2nd and then transferred to Charlotte? Why would I get that today?

Page 3

LOLA: I don't know.
LIEUTENANT MILLER: And I -- and I'm not asking you to answer any questions. You're my sounding board.
LOLA: Yes, I know. I know. And --
LIEUTENANT MILLER: And -- but that just infuriates the living hell out of me, because in the statement that says that the child has a -- none of the -- the parents don't know anything about any falls.
LOLA: Yeah. That's one from on-call that Shondra Tyler went out on the 6th. Me and her sent that out, and we staffed it with them on Monday.
LIEUTENANT MILLER: And I do not --
LOLA: So you haven't --
LIEUTENANT MILLER: I don't have -- there's not a report on it where law enforcement was called --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- or nothing.
LOLA: Uh-huh. Yeah. They had that for the 7th to follow up on.
LIEUTENANT MILLER: Why --
LOLA: Yeah. So you got it today?
LIEUTENANT MILLER: Yeah. I just got it when I walked in the door.
LOLA: I don't know.
LIEUTENANT MILLER: It was sent on the 16th --

Page 4

LOLA: -- which was last --
LIEUTENANT MILLER: -- which would've been last night. Well, it came in at six -- almost seven o'clock last night.
LOLA: Yeah.
LIEUTENANT MILLER: You know, I just -- I try my best.
LOLA: Uh-huh.
LIEUTENANT MILLER: Now, if anything's going to stroke me out, this -- this will.
LOLA: Yeah. The (inaudible) --
LIEUTENANT MILLER: Things like this will, but the other stuff that I know about, we can deal with. But I just -- I don't understand -- they'll send me something over here about a child having sex with somebody.
LOLA: Uh-huh. Oh, that's right away, right? But not the other one.
LIEUTENANT MILLER: Yeah. But they won't send me where a one-year-old child's got damn bruising on its brain.
LOLA: Uh-huh. Yeah. That -- and that was staffed on the 7th because I passed that on to them, and it was discussed, and it's law enforcement referral. So, yeah, I can't explain what happened.
LIEUTENANT MILLER: I guess my main thing is: Did --

EXHIBIT 24

Page 5

1 was DSS called out?
2 LOLA: Yeah, it was. Because I sent Shondra Tyler out.
3 That was --
4 LIEUTENANT MILLER: That day or that night -- whatever
5 that -- whenever it was?
6 LOLA: Yeah. That night I sent her out to the hospital,
7 and then we brought the report in the next day and
8 sent -- and staffed it and passed the report on to
9 the assigned caseworker. And we staffed that case,
10 and they had all the information, and they were
11 going to make their law enforcement referral.
12 LIEUTENANT MILLER: Well, let me ask you this question:
13 Why were we not called that night?
14 LOLA: Because the child was in the hospital, and the
15 parents appeared to be appropriate. And they
16 didn't think that it was -- oh, because the
17 information was -- they thought that we were coming
18 up there to release the babysitter. After the
19 worker went up there and followed up with the
20 report, no doctor had said that the child had a
21 non-accidental injury. Staff thought that DSS was
22 there to release the sitter so they could -- so the
23 sitter could go home, and there was no concerns for
24 the child, that it was accidental.
25 So I didn't send law enforcement up there with

Page 6

1 her on that report. Child was in a safe place.
2 She was -- went up there. She wasn't saying that
3 it was not -- non-accidental, the social worker
4 that had called. There's an injury -- she -- they
5 had that report on -- that baby was there on
6 Saturday.
7 That baby has been to four different doctors.
8 That family picked that -- that child was --
9 November 30th went to the doctor, December 2nd went
10 to Riverview. The 4th -- there was one appointment
11 at Sunshine, and then Friday, the 4th, the baby
12 went to PMC. And then PMC sent the baby to
13 Charlotte on Saturday, and then Sunday the hospital
14 called us.
15 So that baby's had four other -- not hospital,
16 but doctor visits, and the doctor has continuously
17 sent the child home. But the family has responded
18 to the child appearing limp because the -- Friday
19 the incident was the worst. So, no, I didn't send
20 law enforcement out. Child was in a safe place.
21 We have to get the information. We have to find
22 out what's going on.
23 LIEUTENANT MILLER: Uh-huh.
24 LOLA: And we brought the case in the next day and
25 staffed it.

Page 7

1 LIEUTENANT MILLER: Okay. What -- well, I guess -- I
2 guess my question is -- and I'm just -- all I'm
3 doing is throwing stuff at you because I'm trying
4 to figure out what's going on.
5 LOLA: Uh-huh.
6 LIEUTENANT MILLER: Is they're saying -- the parents are
7 saying that -- at least in the DSS report -- that
8 this child hasn't fallen, hasn't hit his head on
9 anything, or none of that stuff.
10 LOLA: Yes. Yes.
11 LIEUTENANT MILLER: And --
12 LOLA: And that's what they told the on-call worker too,
13 that they're not aware. And then it was like they
14 said the same thing. And I'm -- the medical
15 records, I don't know what's happened with those,
16 what -- what the end results were with those. So
17 nobody has an answer as to why or how that child
18 was injured. There was a question of an uncle,
19 though.
20 LIEUTENANT MILLER: Yeah. The --
21 LOLA: Dad and --
22 LIEUTENANT MILLER: The babysitter or the -- or the
23 mother went and picked them up from the daddy and
24 the uncle, or what was -- there was something in
25 there about that.

Page 8

1 LOLA: No. What I remember is: The uncle was with the
2 dad.
3 LIEUTENANT MILLER: Right.
4 LOLA: They were the two that were left alone with the
5 child on one occasion, and that was per the grandma
6 who told the social worker or the nurse at the
7 hospital. So, yeah.
8 LIEUTENANT MILLER: Would that --
9 LOLA: We have 24 hours to make our referral too, and I
10 mean, that's no excuse or whatever, but it's like,
11 "You know what? We'll go out there and we'll
12 initiate our contact, make sure that child -- they
13 don't leave against medical advice." They were
14 cooperative. And then -- then next day, assign it
15 to the caseworker. It's like, "You're the one that
16 needs to get out there and find out what's going
17 on, follow up with that," because we don't need ten
18 caseworkers at court.
19 LIEUTENANT MILLER: Uh-huh.
20 LOLA: I don't know. Devondra's back in the office. I
21 heard her voice. You want to ask her why they
22 waited? I mean, I -- I don't know, W.J.
23 LIEUTENANT MILLER: Okay. Yeah. I definitely want to
24 talk to her. But I just -- you know -- you know
25 I'm going to call you first.

Page 9

1 LOLA: Yeah.
2 LIEUTENANT MILLER: Because I know there's always more
3 to a story than what I'm actually reading here.
4 But I just --
5 LOLA: Yeah.
6 LIEUTENANT MILLER: I -- I can't understand how I -- how
7 I get this, you know, seven or eight days later.
8 LOLA: Yeah. And --
9 LIEUTENANT MILLER: And -- and -- but I get this other
10 crap immediately.
11 LOLA: Yeah. The hospital staff, per Shondra after the
12 -- after she had gone out there and when she was
13 ready to leave, a nurse and another staff person
14 came up to her and said, "So are you releasing the
15 sitter now so they can go home?" And they were
16 surprised that we were even there otherwise,
17 pointing the finger at the parents. Shondra Tyler.
18 And then that was upsetting to me because, like,
19 why -- you thought we would just go up there and
20 release your sitter. We thought you were calling
21 because you thought there was physical abuse, but
22 no doctor had stated that. And Christa's also
23 followed up and called the doctor the next day, or
24 somebody on staff there -- Bridgette, I think.
25 LIEUTENANT MILLER: Okay.

Page 10

1 LOLA: So they would have a bit more information, too,
2 than what would be on that report, but -- you know,
3 I -- it still should've -- we had 24 hours; it
4 still should've gone out on the Monday by the
5 latest.
6 LIEUTENANT MILLER: Yeah. I just don't -- I don't know.
7 LOLA: Yeah. Because you have Shondra Tyler who
8 interviewed the people, and then whoever --
9 Devondra Hill, if she interviewed anybody, would
10 have whatever she has also. So -- but I made the
11 call not to call law enforcement that night.
12 LIEUTENANT MILLER: Okay.
13 LOLA: I had 24 hours. And then it was being passed on
14 to the next worker. So -- but that baby's been to
15 four different appointments prior to getting to
16 Pineville. That did not -- this appears to be
17 something that's been going on since 11/30, and the
18 parents kept taking the child to a doctor or to
19 Riverview Clinic or then to the hospital. And they
20 just kept getting turned around, "Everything's
21 fine. Everything's fine." Except for the 4th.
22 Friday the 4th, that -- the hospital said, "No.
23 Everything's not fine."
24 LIEUTENANT MILLER: Okay. What's -- who was the uncle?
25 because I don't see anything on here about his name

Page 11

1 or anything other than "uncle."
2 LOLA: Oh, okay. Hang on. I'm going to move my phone,
3 and if I lose connection --
4 LIEUTENANT MILLER: Well, I'll tell you what: No.
5 There's no need in you having to deal with this. I
6 left a -- a message for Christa -- Christa Hemmett
7 to call me back.
8 LOLA: Uh-huh. And she's gone on home visits, but she
9 should be back this afternoon.
10 LIEUTENANT MILLER: Right. I've left a message. She
11 can call me on my cell phone or home phone as long
12 as this child seems to be in decent custody right
13 now.
14 LOLA: Yeah. Because it's -- or the child, I think, is
15 at home, right? Is that what your report says?
16 LIEUTENANT MILLER: It doesn't say.
17 LOLA: It doesn't? What -- what's her name?
18 LIEUTENANT MILLER: Her name is -- or his name is [redacted]
19 [redacted]
20 LOLA: [redacted]
21 LIEUTENANT MILLER: [redacted]
22 LOLA: Okay. All right. I'm -- I -- I'll just pull it
23 up right here, and let's see if her dictation shows
24 who that uncle was that she had spoke to, because
25 she was supposed to say. Let's see. It's Owen --

Page 12

1 Jennifer's the -- Brian Carduff is the uncle. He's
2 the paternal uncle, Brian Carduff. "In the
3 beginning, Owen's -- change in Owen's behavior that
4 they first noticed was on 11/28, sleeping, screamed
5 a lot nonstop." They took him to Riverview Clinic
6 on 11/28. Doctor said nothing was wrong. Then --
7 LIEUTENANT MILLER: Do you have the address and
8 telephone number for the uncle?
9 LOLA: No. But I think he lives there with them. My
10 understanding --
11 LIEUTENANT MILLER: At the same house?
12 LOLA: Yeah. My understanding is he's living at that
13 home.
14 LIEUTENANT MILLER: Okay. [redacted]?
15 LOLA: Yes. Yeah.
16 LIEUTENANT MILLER: And -- wait. Are you finding
17 anything else in there?
18 LOLA: Oh, okay. So 11/28 he went to Riverview Clinic.
19 Then on 12/2 he went to Sunshine Peds. Doctor said
20 he had a sore throat -- had a throat infection and
21 a minor cold. 12/4 the baby was limp; they rushed
22 him over to Piedmont. Then he was transferred to
23 Levine. That was 12/5 like around two o'clock in
24 the morning, I guess. I remember there --
25 something said about that. And then -- so that's

Page 13

1 three appointments that he went to where people --
2 because the baby was going limp. And I don't know
3 what the medical records are.
4 My -- she checked out the play packs or
5 whatever the child sleeps in. A small, flat,
6 brownish bruise on the left side of his head was
7 noticed in November, which was probably the 28th.
8 No idea where it came from. "Owen head turns and
9 jerks around sometimes during tummy time on the
10 floor." Oh, uncle has been in their home with
11 either parent.
12 LIEUTENANT MILLER: He's what?
13 LOLA: Uncle might not live there. Uncle said that he
14 never watched the children alone, but he has been
15 in the home with either parent and watched when
16 they did things around the house. So that's
17 probably -- that's probably not the uncle's
18 address. But Devondra or Christa should have that
19 address for the uncle. She doesn't have that in
20 her dictation here. Let's see.
21 Well, and then, too, Levine's stuff -- oh, no.
22 Owen -- our -- we stopped our case so I guess they
23 stopped the case, and the child was allowed to go
24 home. Second T -- second CT scan was stable. That
25 was on 12/7. Owen -- yeah. So he was discharged.

Page 14

1 Okay. I'm not seeing another address for the
2 uncle, but Devondra may have that. What day is
3 that? I mean, that day -- it was done on a Monday.
4 No. She didn't put the address of the uncle in
5 here.
6 LIEUTENANT MILLER: Okay.
7 LOLA: Yeah. Christa will probably follow up with you
8 because she had called and talked to a doctor, and
9 12/7 the hospital could not determine where --
10 whether the injuries are accidental or non-
11 accidental. Bones, eye exam, skeleton survey were
12 negative. His head still appeared swollen, though,
13 on the 7th. Family has no clear history of trauma.
14 The hospital -- however, the hospital cannot rule
15 out any trauma. So their concern was lack of
16 supervision.
17 LIEUTENANT MILLER: Well, see, yeah, that's -- that's
18 my whole thing is: How did this child's head get
19 bruised up like this?
20 LOLA: Uh-huh.
21 LIEUTENANT MILLER: And nobody knows. You know, he
22 wasn't crying sometime?
23 LOLA: He was. He was. See, and that -- all -- he was
24 showing signs and symptoms, and that's why the
25 family started reacting. 12/7, Laura stated, "At

Page 15

1 this point there are no obvious signs of abuse or
2 neglect," but they were going to follow up with the
3 family in two weeks. Yes, there was.
4 LIEUTENANT MILLER: What I'm saying --
5 LOLA: (Inaudible.)
6 LIEUTENANT MILLER: But what I'm saying is --
7 LOLA: Uh-huh.
8 LIEUTENANT MILLER: -- that sometime, if he would've had
9 these bruises come up on his head, he would've
10 started crying at that time.
11 LOLA: Yeah. See, now, they noticed the change in his
12 behavior. He was sleeping a lot, screamed a lot
13 nonstop. That was 11/28. Then he was taken to
14 Riverview. Riverview doctor said nothing wrong
15 with him. "Owen continued the abnormal behavior
16 through the week on 12/1 and went all day and night
17 without urinating."
18 So then they took -- they scheduled an
19 appointment with the pediatrician for the 2nd, and
20 they took the child there. That doctor said a sore
21 throat and a minor cold, no medicine.
22 Then on 12/4, pulling in the driveway, Michael
23 came outside -- Michael, the dad, came outside and
24 said that Owen just went limp. He was still
25 breathing. They rushed him to the hospital. "At

Page 16

1 the hospital, Owen let out a loud scream and took a
2 huge breath." And that's what she put.
3 And then -- so they've noticed these
4 behaviors, and they were following up with the
5 doctor on these behaviors. But nobody -- the
6 doctors were saying everything was fine until
7 Friday the 9th. Mr. Carduff said Owen was sleeping
8 a lot, he wasn't eating. He'd wake -- woke him up
9 to feed him. He'd let out a loud scream, stretch
10 out, was turning red and went limp. So that was
11 the 4th.
12 But they were noticing -- the parents were
13 noticing the child's behavior wasn't -- did not
14 appear right, and they would take the child to the
15 doctor. And there's only that one time where that
16 bruise on his head -- the little brownish -- small,
17 flat, brownish bruise. So that would've -- that
18 was in November. That would've been the 28th.
19 LIEUTENANT MILLER: Uh-huh.
20 LOLA: A small, flat, brownish bruise on the left side
21 of his head; they noticed that. And they did not
22 know where it came from. Again, back to "Owen's
23 head jerks -- turns and jerks around during tummy
24 time on the floor." So it may -- I mean, if it is
25 lack of supervision, you can hit something with it,

Page 17

1 and -- and they weren't in the room, had something
2 there that shouldn't have been. But again, too,
3 he's only a small baby.
4 LIEUTENANT MILLER: Right. I can -- you know, I've got
5 a grandson that's almost one year old, and I know
6 he can bounce, you know --
7 LOLA: Uh-huh.
8 LIEUTENANT MILLER: -- and crack his head, do whatever.
9 But --
10 LOLA: Yes.
11 LIEUTENANT MILLER: -- my thing is -- is, unless you
12 leave him alone --
13 LOLA: Uh-huh.
14 LIEUTENANT MILLER: -- you know, for hours at a time, if
15 a child falls and hits their head hard enough --
16 LOLA: Uh-huh.
17 LIEUTENANT MILLER: -- that there's an internal brain
18 bruise --
19 LOLA: Uh-huh.
20 LIEUTENANT MILLER: -- which my understanding of the --
21 LOLA: Hematomas?
22 LIEUTENANT MILLER: -- falx -- well, the falx subdural
23 hematoma --
24 LOLA: Uh-huh.
25 LIEUTENANT MILLER: You know, other than bruising, you

Page 18

1 know, they'll cry for a little while and then
2 they'll quit or either go to sleep or something
3 like that. But that one that went behind the -- I
4 guess it's behind the skull --
5 LOLA: Uh-huh.
6 LIEUTENANT MILLER: -- you know, that's not something
7 they usually get by just falling.
8 LOLA: Right.
9 LIEUTENANT MILLER: And that's why -- that's -- I guess
10 that's my main concern is that -- had it just been,
11 you know, a couple of bruises where it could've
12 been, you know, the playpen or the crib or
13 something where he climbed up and slipped and fell
14 and hit his head, that's a different story.
15 LOLA: Right.
16 LIEUTENANT MILLER: But when you got a child going limp
17 and, you know, not acting right and doing all that
18 kind of stuff, and then you get in there and you
19 got a bruise behind the skull --
20 LOLA: Right.
21 LIEUTENANT MILLER: -- there's something.
22 LOLA: Yeah. Something happened.
23 LIEUTENANT MILLER: Yeah.
24 LOLA: Something happened. Yeah.
25 LIEUTENANT MILLER: So that's -- I guess that's my

Page 19

1 biggest thing, and then I -- I -- my whole thing
2 was just to call up and bitch.
3 LOLA: Uh-huh.
4 LIEUTENANT MILLER: Because I figured I'd get to the end
5 of it sooner or later, but I just don't like little
6 children -- you know, one minute --
7 LOLA: Right.
8 LIEUTENANT MILLER: One minute -- there's no
9 consistency, I guess, is what I'm saying.
10 LOLA: Yeah. There isn't, W.J. Wholeheartedly, there
11 is not.
12 LIEUTENANT MILLER: And I guess that's what gets me.
13 Because I can get something, you know --
14 LOLA: Uh-huh.
15 LIEUTENANT MILLER: -- like these kids with the
16 dogfighting and stuff, you know.
17 LOLA: Oh, yeah, that was a good one.
18 LIEUTENANT MILLER: You know, we get those and then we
19 got the ones whose Mama and Daddy's smoking pot,
20 you know, and that kind of stuff, you know,
21 immediately --
22 LOLA: -- and these ones you're not?
23 LIEUTENANT MILLER: -- so -- huh?
24 LOLA: And this one you're not?
25 LIEUTENANT MILLER: And this one we get, you know -- on

Page 20

1 the 6th it was evidently staffed, from what I
2 see --
3 LOLA: The 7th because -- oh, sorry. I keep saying the
4 -- no. The 7th because we -- I was on call with
5 Shondra, and Shondra and I received that report.
6 At 5:01 she got the phone call from the hospital
7 that night.
8 LIEUTENANT MILLER: Uh-huh.
9 LOLA: And she called me and told me about it, and I
10 sent her out to just go interview the family. And
11 then we staffed that case on Monday morning and
12 gave them the information and transferred it to
13 Christa and Devondra because it was their assigned
14 case.
15 LIEUTENANT MILLER: I guess -- and that's ten days ago
16 is what I'm saying.
17 LOLA: Yes. Yes. Uh-huh.
18 LIEUTENANT MILLER: But anyway, I miss talking to you.
19 I don't -- I don't see you enough.
20 LOLA: Yeah. It has been quite a while. It's like,
21 shoot, I put -- put my phone on, but darn it, you
22 would've called me today because I didn't, but I'm
23 reaching for it right now to turn it on.
24 LIEUTENANT MILLER: Yeah. Well, I've called your cell
25 phone, and you've told me that it wasn't working

Page 21

1 that good.
2 LOLA: Oh, it is now. They -- they -- she -- it's been
3 fixed because they had gave -- given us new phones,
4 and they had trouble with switching the phone line
5 over or whatever -- however that works when you
6 transfer to a new phone --
7 LIEUTENANT MILLER: Right.
8 LOLA: -- phone company. But it works now, unless my
9 message still says it's not working. I didn't
10 change it. I don't know. But it's working. I've
11 been carrying it and turning it on.
12 LIEUTENANT MILLER: Well, that's good.
13 LOLA: Yeah.
14 LIEUTENANT MILLER: I'll have to start aggravating you
15 some more now.
16 LOLA: I know. It's like, okay. All right. So --
17 LIEUTENANT MILLER: Well, anyway, like I say, I left a
18 message for Christa to give me a call because we're
19 just going to need to meet about this one so that
20 we can figure out --
21 LOLA: Okay.
22 LIEUTENANT MILLER: -- you know, if there's anything
23 else that needs to be done. We definitely need to
24 find out what the uncle's deal is, who he is, you
25 know, all that good stuff.

Page 22

1 LOLA: Yeah, because the uncle -- because Grandma is the
2 one that pulled the nurse aside, I guess Friday --
3 Friday night -- well, 2 a.m. Saturday morning or
4 whatever on Saturday Grandma told the nurse or the
5 social worker that the uncle had been with the
6 child too. It was the uncle and the dad.
7 LIEUTENANT MILLER: Uh-huh.
8 LOLA: So Grandma had some concerns about the uncle.
9 And Shondra was saying to me, "How do I address
10 that? Because he's saying" -- after she talked to
11 him and then she came out and said, "Okay, Lola.
12 He's saying he never had the child alone." And I
13 gave her a different approach, and he did admit
14 that -- then he did say, well, he was alone when
15 the parents -- with the parents. But, yeah, he --
16 he -- later he changed his story. But Grandma had
17 suspicions of the uncle.
18 LIEUTENANT MILLER: Uh-huh.
19 LOLA: So -- and we shared all our information with them
20 -- with Christa and Devondra. We shared our
21 information on Monday morning with what we had.
22 And we told them, so we -- they knew about the
23 uncle and everything and the information that the
24 hospital had said so, yeah.
25 LIEUTENANT MILLER: Okay.

Page 23

1 LOLA: They -- they -- they should have it, and she
2 should be interviewing him or talking to him. But,
3 yeah, my understanding was they were (inaudible)
4 could go ahead and do a law enforcement referral
5 that day.
6 LIEUTENANT MILLER: Well, yeah, and I don't -- I'm easy
7 as hell to get along with.
8 LOLA: Yeah.
9 LIEUTENANT MILLER: You know, and I -- if there's a
10 problem or something, I'll -- and most of them call
11 me. Y'all call me --
12 LOLA: Uh-huh.
13 LIEUTENANT MILLER: -- you know, immediately and say --
14 but I haven't heard from Devondra on this one yet.
15 LOLA: Oh, wow.
16 LIEUTENANT MILLER: Everybody usually calls me and says,
17 "Hey, I'm going to, you know, send this referral
18 over." And by the time I can get to the fax
19 machine, that's where it's at.
20 LOLA: It's there. Yeah.
21 LIEUTENANT MILLER: You know, but everybody usually
22 gives me a heads up that it's coming, which they
23 really don't need to do, but, you know, they can
24 call me later and say, "Did you get it?" --
25 LOLA: Right.

Page 24

1 LIEUTENANT MILLER: -- because sometimes I don't get
2 them, and they have to resend them.
3 LOLA: True. True.
4 LIEUTENANT MILLER: But -- and -- and if one's -- and if
5 one's late, just give me a call and say, "Hey" --
6 LOLA: Yep.
7 LIEUTENANT MILLER: -- "you know, I'm going to get it
8 to" --
9 LOLA: Yep.
10 LIEUTENANT MILLER: -- "I'm -- I'm going to let you know
11 right now this is the names and stuff, but it's
12 going to be a day or two before you actually get
13 all the paperwork because I'm" --
14 LOLA: Uh-huh.
15 LIEUTENANT MILLER: -- "trying to put something
16 together." And I know y'all are busy. That's all
17 they got to do is call me and tell me that instead
18 of letting me find out ten days later that we had
19 this with no phone calls.
20 LOLA: Yeah.
21 LIEUTENANT MILLER: Because I swear I don't want to get
22 in -- you know, I ain't going to get nobody in
23 trouble if I can damn help it.
24 LOLA: Right.
25 LIEUTENANT MILLER: But I may ask the wrong person about

Page 25

1 something one day and, you know --
2 LOLA: Uh-huh.
3 LIEUTENANT MILLER: -- the next thing you --
4 LOLA: Uh-huh.
5 LIEUTENANT MILLER: -- know your butt's on the chopping
6 block.
7 LOLA: Yep. And consistency again. Not everybody on
8 call is following up, making that referral to law
9 enforcement. It's going to the caseworker the next
10 day. "Here's what you're going to need to do:
11 You're going to need to follow up with law
12 enforcement and make your referral," because, if it
13 does go to court, we don't need ten workers and, if
14 one goes out there on call, puts the situation in
15 place, makes sure things are safe and they're at
16 the hospital, that's fine; they're safe. Next day
17 the next person assigned the case needs to follow
18 up, get with law enforcement, and they run with it.
19 LIEUTENANT MILLER: Yeah.
20 LOLA: So -- and then -- so that can go back and forth,
21 back and forth on how that goes. But, heck, I'll
22 be checking every darn report. For the county,
23 we'll just go ahead and send you guys out there
24 right off the bat so I don't have to have this
25 conversation about why I didn't send her. Yep.

Page 26

1 LIEUTENANT MILLER: You know, and -- and --
2 LOLA: And then I don't want one like we had with
3 Shaquita Gladden where they took the babies away
4 from Daddy and you were out there on that case.
5 LIEUTENANT MILLER: Yeah. And I -- you know, and I
6 understood, and I tried to explain to him what it
7 was. I understood that to a -- you know, to a
8 point. That wasn't -- I don't think that was a big
9 deal. But my big deal was going to be -- is
10 drawing that thing out after we'd done decided, you
11 know, we wasn't going to keep that kid for no 45
12 days.
13 LOLA: Yeah.
14 LIEUTENANT MILLER: After about three days, we'd done
15 figured out there wasn't nothing going to happen.
16 LOLA: Right.
17 LIEUTENANT MILLER: You know, that was bull.
18 LOLA: Yes. Yeah.
19 LIEUTENANT MILLER: But, yeah, no. I -- I -- I don't
20 have a problem with taking or not taking -- well, I
21 don't have a problem with taking children if we
22 need to at that time --
23 LOLA: Right.
24 LIEUTENANT MILLER: -- just for safety's sake.
25 LOLA: Uh-huh.

Page 27

1 LIEUTENANT MILLER: But if -- if anybody thinks I'm
2 going to back them up that two days from now we
3 find out that there's nothing -- his story's valid
4 and there was no problem there, it was an accident
5 and all that kind of stuff, if they think I'm going
6 to ride 45 days out with them on "just because" --
7 LOLA: Uh-huh.
8 LIEUTENANT MILLER: -- they're wrong. I'm going to --
9 I'll switch to the other side in a minute and say,
10 "Hey, you need to give these kids back." Just like
11 I told -- told them.
12 LOLA: Yeah.
13 LIEUTENANT MILLER: You know, give these kids back. Let
14 that man get back around these children. Hell, he
15 didn't do that on purpose.
16 LOLA: Exactly.
17 LIEUTENANT MILLER: You know --
18 LOLA: Yeah.
19 LIEUTENANT MILLER: Now, I'll -- I'll go -- I'll go help
20 you get one in a minute. In fact, I got one here
21 -- the other one I was going to ask you about is
22 Ashley Nicole Sigmond. We went out yesterday -- or
23 day before yesterday to Hickory Grove Elementary
24 School --
25 LOLA: Yes.

Page 28

1 LIEUTENANT MILLER: -- and met with Ashley Magwood.
2 LOLA: Okay.
3 LIEUTENANT MILLER: And they EPC'ed Ashley Sigmond.
4 LOLA: Okay.
5 LIEUTENANT MILLER: And I don't know why because I don't
6 have any paperwork on that one either. If there --
7 and even if I need any.
8 LOLA: All right. Okay. Her super is Diane, and I know
9 Diane's in the office. I think Ashley still is.
10 So EPC'ed her on Wednesday, you said?
11 LIEUTENANT MILLER: Yeah.
12 LOLA: Last night?
13 LIEUTENANT MILLER: No. On the 15th.
14 LOLA: 15th. 15th.
15 LIEUTENANT MILLER: At 8:41 --
16 LOLA: Tuesday night.
17 LIEUTENANT MILLER: -- a.m.
18 LOLA: So they would've gone to court this morning,
19 because it would've had to have had their probable
20 cause hearing. Okay.
21 LIEUTENANT MILLER: This is patrol -- Mosley's the one
22 went with them. But I just -- I was just wondering
23 -- and it may not have anything to do with us.
24 LOLA: Uh-huh.
25 LIEUTENANT MILLER: But usually it's -- if y'all EPC

Page 29

1 one, there's definitely some legal or criminal
2 ramifications somewhere, unless somebody's just so
3 poor, you know, they can't help theirselves or
4 something like that. I don't want to get involved
5 in some of that stuff sometimes. But, you know,
6 usually, if y'all EPC one, there's criminal --
7 possible criminal charges somewhere.
8 LOLA: And there was only the one child that was taken
9 into care, W.J.?
10 LIEUTENANT MILLER: That's all I'm showing.
11 LOLA: Okay.
12 LIEUTENANT MILLER: Let me look.
13 LOLA: May have been a dirty house too. What -- what --
14 is it grandparents who have custody, or is it a mom
15 and dad?
16 LIEUTENANT MILLER: Let me see here.
17 LOLA: I think that's the dirty house, and I think it's
18 the -- there's two grandparents that have custody
19 of them.
20 LIEUTENANT MILLER: I don't have parents' names on this
21 report or nothing else. All I've got is "DSS York
22 County" and "Ashley Nicole Sigmond who is 11 years
23 old."
24 LOLA: And she might have --
25 LIEUTENANT MILLER: And her address in York -- I mean,

Page 30

1 in Sharon.
2 LOLA: Yep. She has a brother. That one is familiar.
3 It is the grandparents who have -- it is the
4 grandparents who have custody of her, and she has a
5 sibling. And theirs was in reference to a filthy,
6 deplorable environment, and the grandparents were
7 told to correct that situation and, if they didn't,
8 that DSS was added -- DSS was going to take action
9 to get --
10 LIEUTENANT MILLER: Okay.
11 LOLA: -- them into care. So that -- that is over a
12 home environment.
13 LIEUTENANT MILLER: Okay.
14 LOLA: That is a -- they're saying the home was in
15 disarray, human feces on the floor.
16 LIEUTENANT MILLER: Human?
17 LOLA: Yeah.
18 LIEUTENANT MILLER: Geez.
19 LOLA: Full -- home full of clutter, had a foul odor.
20 Grandma has a pot by her bed and uses it as a
21 toilet, which it was terrible. Nine cats.
22 Grandfather had to be transported to the hospital
23 due to infection from the cats in the bed with him.
24 Timothy poops on him -- has bowel movements on
25 himself. And that's documented and that -- there

Page 31

1 is records on that.
2 LIEUTENANT MILLER: Hell, somebody needs to EPC him, it
3 sounds like.
4 LOLA: Yeah. I don't understand why he wasn't brought
5 in. Linda has one leg amputated, may have to have
6 another one removed. Continues to be unkept and
7 unsafe for the children. They were told to clean
8 it. And I believe law enforcement, the first time,
9 had given them the option and then said they would
10 come back and follow up with the family, and DSS
11 said the same thing. So that home did not -- the
12 environment did not improve. So that is why the
13 child --
14 LIEUTENANT MILLER: Where's Mama and Daddy?
15 LOLA: -- were taken. They're -- they don't have
16 custody of the kids so they don't count anymore.
17 Mommy and Daddy is Linda and -- let me get that.
18 Linda and -- yeah. She's a -- Linda and who?
19 Linda and Lanny.
20 LIEUTENANT MILLER: Linda and Lanny who? Sigmond?
21 LOLA: Sigmond. And Robert Sweeny was the dad and Lisa
22 Rhodes was the mom, but they -- if I recall
23 correctly, they were TPR'ed, so we don't count
24 them. They're not -- they don't count anymore.
25 They're not the parents.

Page 32

1 LIEUTENANT MILLER: Damn, if they're worse than the
2 grandparents, geez.
3 LOLA: Yeah. Eh? And so we're -- I mean, it's the
4 grandparents who are as the custodial parents.
5 LIEUTENANT MILLER: Yeah.
6 LOLA: They are the ones that are responsible for the
7 children; they have them. And actually, both of
8 them are in care. Yeah. Timothy and Ashley are
9 both in care -- they are both in foster care.
10 LIEUTENANT MILLER: Okay. Well, I don't need to --
11 LOLA: Yeah. That -- that -- that was a deplorable
12 home.
13 LIEUTENANT MILLER: Yeah.
14 LOLA: That was a very deplorable home.
15 LIEUTENANT MILLER: Well, there's no -- and -- and from
16 what you've just told me, there's nothing -- you
17 know, what are we going to do? Go lock them old
18 people up? They've got enough damn problems of
19 their own.
20 LOLA: I know. Yes. Yes.
21 LIEUTENANT MILLER: Yeah. But that's cool. We -- long
22 as I don't get that one, that'll be fine.
23 LOLA: Yes.
24 LIEUTENANT MILLER: I just wanted to ask about it
25 because I got it --

Page 33

1 LOLA: Yeah.
2 LIEUTENANT MILLER: -- in the reports this morning so --
3 LOLA: Yeah. So -- and, see, that -- see, those are --
4 those -- some of those ones where we do -- because
5 the home environments show physical neglect and
6 whether or not they can be charged. But, you know,
7 they're old; they're -- and then, too, the court
8 ends up throwing them out as a rule anyways,
9 especially family court.
10 LIEUTENANT MILLER: Yeah. Okay.
11 LOLA: All right. So that works.
12 LIEUTENANT MILLER: That works. You're always a lot of
13 help.
14 LOLA: All right. Great, and I will send law
15 enforcement out there with every worker if it's
16 York County.
17 LIEUTENANT MILLER: Do what? Say that again.
18 LOLA: I will be sending law enforcement out there with
19 every worker when I'm on call if it's York County
20 -- to the hospital.
21 LIEUTENANT MILLER: Now you know that ain't no good --
22 that ain't no -- the way I called you, girl. See,
23 the only way I learn stuff is by asking questions.
24 LOLA: Uh-huh.
25 LIEUTENANT MILLER: And that's why I asked the question

Page 34

1 is why were we not called the night that the child
2 went to the hospital.
3 LOLA: Yeah. Child --
4 LIEUTENANT MILLER: And with that background, see,
5 that's --
6 LOLA: Yeah.
7 LIEUTENANT MILLER: This -- if -- if you listen to what
8 I'm trying to tell you is, if Devondra would've
9 called or sent this in eight days ago --
10 LOLA: Uh-huh.
11 LIEUTENANT MILLER: -- we wouldn't be having this
12 conversation right now --
13 LOLA: True.
14 LIEUTENANT MILLER: -- because somebody would've already
15 been assigned it and it would've been all -- they
16 would've already had a meeting, and we would've
17 been done with this. Doesn't have anything to do
18 with whether or not -- you had a reason not to call
19 us --
20 LOLA: Uh-huh.
21 LIEUTENANT MILLER: -- that night. I understand that.
22 It's not you that got me to call you tonight and --
23 LOLA: No.
24 LIEUTENANT MILLER: -- and -- or to call you today --
25 LOLA: Today.

Page 35

1 LIEUTENANT MILLER: -- and question you on this stuff.
2 It was Devondra --
3 LOLA: Right.
4 LIEUTENANT MILLER: -- for not doing it.
5 LOLA: Yeah. What happened?
6 LIEUTENANT MILLER: Right.
7 LOLA: Why the time lapse? Why the time lapse?
8 (Inaudible.)
9 LIEUTENANT MILLER: Yeah. Why is there a ten-day lapse
10 between the time you were assigned it and I get
11 it --
12 LOLA: Uh-huh.
13 LIEUTENANT MILLER: -- and there's possible criminal,
14 you know, charges here.
15 LOLA: Uh-huh.
16 LIEUTENANT MILLER: Not that she --
17 LOLA: Twenty-four hours.
18 LIEUTENANT MILLER: -- that they had been there four
19 times -- you know, they'd been to the doctor four
20 times, and finally, you know, the child's on the
21 way out of here, I guess --
22 LOLA: Uh-huh.
23 LIEUTENANT MILLER: -- and they grab her up and take her
24 to the hospital and then they transfer her to
25 Charlotte to Levine, which I love Levine. I don't

Page 36

1 know what nobody else does, but I love them.
2 LOLA: Yes.
3 LIEUTENANT MILLER: But they -- that -- that was my
4 thing. And the question -- see, I didn't realize
5 all that, and that's why I asked you those
6 questions.
7 LOLA: Uh-huh.
8 LIEUTENANT MILLER: You know, and you have enough
9 sense --
10 LOLA: Uh-huh.
11 LIEUTENANT MILLER: -- to know whether to call us or
12 not. I'm not questioning your ability by no means.
13 LOLA: Uh-huh.
14 LIEUTENANT MILLER: But, see, I didn't know any of that.
15 LOLA: Right.
16 LIEUTENANT MILLER: Because that -- that would've been
17 my first question to Devondra is: "Why didn't we
18 get called out that night?"
19 And she'd have said, "Well, they've already
20 taken her to the -- or taken him to the doctor four
21 times, and the doctors kept saying that it's okay,
22 you know, it's just bruises. And then, you know,
23 this happens."
24 "Okay. Well, I understand that."
25 LOLA: Right.

Page 37

1 LIEUTENANT MILLER: That's why we didn't get called out,
2 because they -- it was just -- you know, they
3 really tried.
4 LOLA: Uh-huh.
5 LIEUTENANT MILLER: So don't take offense to that
6 because that's not --
7 LOLA: No. I'm not going to. No, no.
8 LIEUTENANT MILLER: -- that's not what I said.
9 LOLA: Uh-huh.
10 LIEUTENANT MILLER: You know, nor is the --
11 LOLA: It's just the ten-day wait. What happened?
12 LIEUTENANT MILLER: Right.
13 LOLA: Yes. Yes. Yeah.
14 LIEUTENANT MILLER: So --
15 LOLA: Yeah, I can't answer. I don't -- I don't have
16 the answer.
17 LIEUTENANT MILLER: Yeah. Well, we'll -- I'll deal with
18 it. I'm -- you know, but like I say, there's no
19 need in them -- if you got a problem with a case or
20 something or you're -- you know, and I know y'all
21 are covered up. There ain't no two ways about it.
22 LOLA: Uh-huh.
23 LIEUTENANT MILLER: Give me a call and let me know
24 you're covered up, and just tell me what you going
25 to send me.

Page 38

1 LOLA: Right. Okay. Yeah.
2 LIEUTENANT MILLER: You know, and if need be, hell, I'll
3 come over there and fax it to myself, you know? If
4 you don't have a lot, just give me whatever you can
5 give me so we can get started with you. We're --
6 you know, we're --
7 LOLA: Exactly.
8 LIEUTENANT MILLER: -- supposed to work as a team.
9 We're not supposed to be pulling away from each
10 other.
11 LOLA: No. Exactly.
12 LIEUTENANT MILLER: So --
13 LOLA: That -- that's true. Yeah. And you know what
14 surprises me too, though, is how come Levine's
15 didn't call law enforcement because they've done --
16 they've been good that way too doing that.
17 LIEUTENANT MILLER: Yeah. I don't understand that
18 either because we --
19 LOLA: She said they never called.
20 LIEUTENANT MILLER: -- got the call -- we got the call
21 from Levine's when that little boy came up there
22 with his broken arm.
23 LOLA: Yes.
24 LIEUTENANT MILLER: Or from Piedmont. Not -- not
25 Levine's. But from -- Piedmont even called.

Page 39

1 LOLA: Yeah.
2 LIEUTENANT MILLER: Because --
3 LOLA: Yeah. It's like this one really fell through the
4 cracks because nobody -- PMC didn't call law
5 enforcement on that one, and then Levine's never
6 called law enforcement. It's like, "Holy crap."
7 It's like oh --
8 LIEUTENANT MILLER: Do y'all -- let me ask you this
9 question too: How do y'all deal with DHEC? Do
10 y'all want a -- never mind.
11 LOLA: Department of Health and Environmental Control?
12 LIEUTENANT MILLER: Yeah.
13 LOLA: We don't have too much dealings with them from a
14 CPS perspective.
15 LIEUTENANT MILLER: I cannot get these people to
16 understand that it is okay for a 14-year-old and a
17 16-year-old to have sex.
18 LOLA: Oh, I know. Because, remember, Lisa had that big
19 meeting, and then she never did send out that
20 letter. We have to wait till February when she'll
21 send out that letter.
22 LIEUTENANT MILLER: Well, I told -- I've called this
23 lady. She keeps sending these things over here
24 with nobody's name or nothing on them.
25 LOLA: Oh, yeah because that's confidentiality, right?

Page 40

1 LIEUTENANT MILLER: Bull shit.
2 LOLA: Yeah. How you going to find your client if -- if
3 she's --
4 LIEUTENANT MILLER: Oh, you've got to call them back and
5 give them this client number; then they can tell
6 you over a phone that could be tapped, you know?
7 LOLA: Right.
8 LIEUTENANT MILLER: And I'm sitting -- I'm sitting there
9 going, "Ma'am, DSS and us fax stuff back and forth
10 every day" --
11 LOLA: Yeah. You're law enforcement.
12 LIEUTENANT MILLER: -- "over children's names, their
13 medical records. We -- I mean, we get all that
14 stuff back and forth." I said, "And furthermore,
15 this is not HIPAA."
16 LOLA: No. That's not. Not with law enforcement.
17 LIEUTENANT MILLER: Yeah. This is a law enforcement --
18 this -- I mean, it doesn't even -- this category
19 does not even fall under HIPAA.
20 LOLA: No. No. Because there -- the law, too, says
21 that any child victim of abuse, HIPAA does not
22 apply.
23 LIEUTENANT MILLER: Right. And if -- and this is a
24 crime --
25 LOLA: Yeah.

Page 41

1 LIEUTENANT MILLER: If you -- if you're sending it to me
2 because you think it's a crime, it's not HIPAA-
3 protected.
4 LOLA: Exactly. And that's in that PMC booklet too.
5 LIEUTENANT MILLER: I -- I do not know why DHEC can't --
6 and -- and I told her, I said, "Well, maybe --
7 maybe you're not the person I need to talk to.
8 Who's your supervisor or the director?"
9 LOLA: Right.
10 LIEUTENANT MILLER: I said, "Hell, let's go all the way
11 up to the top and talk to the director."
12 LOLA: That's right too. Because we get some from --
13 and I think it is DHEC -- Child Resource
14 Development Center. They'll do that with us with
15 when they're trying to send over a referral. And
16 it's like, "How can we proceed if you don't have
17 the -- can't give us the information, we can't take
18 your intake."
19 LIEUTENANT MILLER: Yeah. This is --
20 LOLA: It is -- Katie -- Katie's a bad person to deal
21 with.
22 LIEUTENANT MILLER: Well, I can't read this woman's
23 name, which I -- if I was them, I wouldn't write my
24 name on it either. I think Maloney or something
25 like that. It's a nurse. But she sends it over,

Page 42

1 "Date of request" -- or it says, "Report of sexual
2 activity of a minor under 16. 15-year-old" -- a
3 girl that's 15 year old, 4 months, and 23 days is
4 having sex with a 16-year-old.
5 LOLA: Oh.
6 LIEUTENANT MILLER: And I said -- and I said, "Did he
7 rape her?"
8 LOLA: Right.
9 LIEUTENANT MILLER: "Well, no."
10 "Did he force her to have sex?"
11 "No."
12 "Are they having consensual sex?"
13 "Yeah."
14 I said, "That's not against the law."
15 LOLA: No.
16 LIEUTENANT MILLER: "Well, they changed the law."
17 I said, "Yeah. They changed it and dropped it
18 a year."
19 LOLA: Uh-huh.
20 LIEUTENANT MILLER: I said, "A 14-year-old can have sex
21 with another person that has not reached their 19th
22 birthday yet."
23 LOLA: Yes.
24 LIEUTENANT MILLER: I said, "But here's the catch, now,
25 if y'all want to send me one that's 15-year-old

Page 43

1 having sex with a 19-year-old, you feel free to do
2 that, because that's against the law."
3 LOLA: Uh-huh.
4 LIEUTENANT MILLER: I said, "Now, it's ignorant, but
5 it's against the law."
6 LOLA: Uh-huh.
7 LIEUTENANT MILLER: I said, "But don't send me any more
8 of these people unless there is a charge of some
9 sort of criminal act" --
10 LOLA: Right.
11 LIEUTENANT MILLER: -- "because a 14-year-old and a 16-
12 year-old and a 15-year-old and a 17-year-old and
13 all yada, yada, yada, as long as they haven't
14 reached their 19th birthday, it's okay."
15 LOLA: So did they acknowledge what you were telling
16 them?
17 LIEUTENANT MILLER: No. Hell, they sent me another one
18 two days later. I'm going to start -- I'm going to
19 get me a "Reject" stamp --
20 LOLA: Oh, cute.
21 LIEUTENANT MILLER: -- and I'm going to stamp it and
22 send it back to them.
23 LOLA: I know because it's like people sometimes -- it's
24 like, "What do you -- what do you not hear? It's
25 not a crime. This is not a crime, so it's not

Page 44

1 something that goes to law enforcement."
2 LIEUTENANT MILLER: I -- I don't know. I -- it just
3 drives me nuts. It's -- but --
4 LOLA: Uh-huh.
5 LIEUTENANT MILLER: -- the actual crimes aren't going to
6 be the ones that tick me off.
7 LOLA: Oh, exactly. Exactly. It's in --
8 LIEUTENANT MILLER: -- the bureaucracy and --
9 LOLA: Uh-huh.
10 LIEUTENANT MILLER: -- bull shit that you have to put up
11 with.
12 LOLA: Oh, yeah. Yeah. We -- we had a report today
13 about a faint scratch and there's an open treatment
14 case and it was indicated for physical neglect.
15 And they were giving it to us as a new report for
16 physical abuse. I said, "You know what? No. How
17 about the treatment worker just go ahead and take a
18 look at the situation, see if there is need for a
19 new report." It's a faint scratch.
20 LIEUTENANT MILLER: And -
21 LOLA: You don't need to do a full-blown investigation.
22 LIEUTENANT MILLER: And how many different ways that
23 could've happened?
24 LOLA: Yeah. That's what I said. I said, "Go find out
25 if his cat scratched him. Can you -- can you find

Page 45

1 that out for me?" I mean, please, anybody can get
2 scratched easily. A scratch -- a faint scratch,
3 but kid said something about "whooping." Well, you
4 know what? Treatment's in there. Treatment knows
5 what's going on in the household. Go ask Mom,
6 "Hey, are you actually whooping your kids? You
7 told me that you weren't, but your child's saying
8 that you do now. Is this true?" Unh-unh. I mean,
9 we have, like, for -- for-your-information-only,
10 like, markings that we can do with the report. If
11 there's an open case already, we don't need to go
12 back in there and do a new investigation on
13 everything. It's like, "You go out there and tell
14 us what you see. Is there concerns for something
15 new? Then you can make a new report."
16 But we have counselors calling, "There's a
17 faint scratch on him, and he says his mom whoops
18 him." Okay.
19 LIEUTENANT MILLER: Yeah.
20 LOLA: Never seen bruises or marks but there's a faint
21 scratch today.
22 LIEUTENANT MILLER: Yeah. That's just --
23 LOLA: Yeah. It's like you deal with some of the crap
24 -- crap you get. And that's serious, still calling
25 us from the hospital with the same thing --

Page 46

1 LIEUTENANT MILLER: Yeah.
2 LOLA: -- 15-year-old having sex with a 16-year-old.
3 Okay.
4 LIEUTENANT MILLER: Yeah. Did he -- and my first thing
5 is: Did he rape her or force her to have sex?
6 LOLA: See, and they're not. And -- and -- and Becky
7 has a good relationship -- I think -- I forget who
8 the woman is now -- with the social worker at the
9 hospital who's calling and making the reports and
10 that -- that social worker's saying, "No. But we
11 were just told that we have to call you." It's
12 like, okay.
13 LIEUTENANT MILLER: "Well, you called and you said it.
14 Goodbye."
15 LOLA: Uh-huh. Uh-huh. We do, and you notice you're
16 not getting them because we're not sending them to
17 you. But we'll lie through our teeth if we have
18 (inaudible).
19 LIEUTENANT MILLER: Girl, you ain't right. You're not
20 right.
21 LOLA: Yeah.
22 LIEUTENANT MILLER: Well, it was sure good to talk to
23 you.
24 LOLA: Yeah. You too.
25 LIEUTENANT MILLER: I -- I know you probably didn't, but

Page 47

1 I enjoyed it.
2 LOLA: Yeah. Are you taking some Christmas vacation
3 here next week?
4 LIEUTENANT MILLER: No. I'm on call next week.
5 LOLA: Oh, wow. Okay. We're hoping it's quiet, right?
6 LIEUTENANT MILLER: Yep. Are you on call?
7 LOLA: Yeah. I have the 24th.
8 LIEUTENANT MILLER: Ooh, good.
9 LOLA: And I want a quiet -- well, I only have the one
10 day, the 24th.
11 LIEUTENANT MILLER: Oh, hell, I got all next week.
12 LOLA: But I want it quiet.
13 LIEUTENANT MILLER: But I don't have to go unless my
14 detective can't handle it.
15 LOLA: Oh, okay That's how you get up there then, eh?
16 LIEUTENANT MILLER: Yep.
17 LOLA: Oh, all right.
18 LIEUTENANT MILLER: (To unknown male) Huh? No I had
19 more important shit to do besides iMapping. I hate
20 I missed it.
21 UNKNOWN MALE: It was good.
22 LOLA: All right. Well, if I don't catch -- hear from
23 you next week, you have a Merry Christmas.
24 LIEUTENANT MILLER: You do the same and have a safe one.
25 And --

Page 48

1 LOLA: Yes.
2 LIEUTENANT MILLER: But if you need anything, you know
3 who to call.
4 LOLA: Oh, yeah. And -- and --
5 LIEUTENANT MILLER: You've got my cell phone number.
6 LOLA: And I will not hesitate on the 24th at all if
7 York County is needed and if there's a referral to
8 law enforcement.
9 LIEUTENANT MILLER: You won't have to worry about it.
10 You don't have to worry about it.
11 LOLA: All right.
12 LIEUTENANT MILLER: Well, you take care, and it was good
13 talking to you.
14 LOLA: Same to you.
15 LIEUTENANT MILLER: All right.
16 LOLA: All right. Bye, W.J.
17 LIEUTENANT MILLER: Bye-bye. Bye-bye.
18 LOLA: All right.
19 (End of recording.)
20 (*This transcript may contain quoted material.
21 Such material is reproduced as read or quoted
22 by the speaker.)
23 (**Certificate accompanies sealed original
24 only.)
25

EXHIBIT

"25"

PLAINTIFF'S EXHIBIT 20

DATE	TIME	RECORD PROGRESS OF CASE, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT.	ABBREVIATIONS USE	ABBREVIATIONS DO NOT USE
12/7/09		NSURG		
	1000	Family reports he [illegible] po		
		chronic reflux [illegible]	Units	u or U
		Parents have noticed [illegible]		
		[illegible] if present from birth.		
		Happy, alert. NAE.		
		In prone position HC bulging [illegible]	Inter-national units	IU
		HC - 42.5cm		
		- will obtain HC [illegible] from Peds office	X mg (Never use a trailing zero)	X.0 mg
		Dr. Baxter (803-980-7337)		
		left message		
		[illegible]	0.X mg (Always use a leading zero)	.X mg
		12-7-09 1115		
12-7-09		Neurosurg	daily	qD
1845		Alert. Doing well overall. Repeat CT shows stable extra-axial collections (2) larger than (1). OK to discharge under supervision — will need to see in f/u 2-3 weeks. Should be instructed prior to dischg re. s/s of ICP.	every other day	qOD
			Mor-phine	MS or MSO4
			Mag-nesium Sulfate	MgSO4

Carolinas HealthCare System
PROGRESS RECORD
(3/07)

09339-00393
C000545-0[redacted]
ATT PHY: 68247 CHIPS, [redacted]
12/05/09 DOB: [redacted]

EXHIBIT 25

CMC (12.05.09) 0039

EXHIBIT

"26"

PLAINTIFF'S EXHIBIT 32

Levine Children's Hospital | Specialty Centers

(704) 448-KIDS (5437)

(888) 279-KIDS (5437)

HIST. NO: 000-545-02-19

PATIENT: [redacted]
Date of Birth: [redacted]

ACC. NO: [redacted]

DISCHARGE SUMMARY

Children's Hospital Inpatient Service (CHIPS) team A

Date of Admission: 12/05/2009
Date of Discharge: 12/08/2009

Principal Diagnosis:
1. Subdural Hemorrhage

Hospital Course: This patient is a 2-month-old previously healthy Caucasian male who presented to the emergency department at Levine Children's Hospital from Piedmont with ALTE. The patient's parents report that around 1630 on Friday evening, the patient had an episode shortly after a feed, where he cried out and then arched his back. He went limp for approximately 10 minutes afterwards. There is no color change, no cyanosis, no loss of consciousness. The patient did not have any shaking or seizure-like movements at the time. Parents report that he was whimpering around with the 10 minutes mark and when he was removed from his car seat at the emergency department, he then cried and began acting more normally. They also reported that he has been more sleepy since that time and has been fussy but somewhat consolable. He was noted to have a minor cold about one week ago and what the parents describe as a throat infection. The patient in addition, today has had nonbloody, nonbilious vomiting that has been nonprojectile in nature after all feeds last evening. There is marked decrease in urine output and the patient has only had one wet diaper so far today as well as the urine that was obtained when he was catheterized. The patient received one dose of Rocephin at the outside hospital before being transferred here, after labs were obtained for a full sepsis workup.

Neuro: On admission, it was noted that the patient had a full fontanelle. A CT scan revealed a R sided subdural hemorrhage. During his stay here, he had no more ALTE-like episodes and acted like himself. He had a repeat CT scan which demonstrated no acute change.

CV: No tachycardia / bradycardia. Stable.

Pulm: The patient was settling well throughout the visit.

FEN/GI: The patient was on a regular age appropriate diet during his course here.

Renal: Following admission, the patient was making adequate urine.

Hema/ID: The patient's hemoglobin rose from 8.3 to 9.4. Stable otherwise. Low suspicion for infection.

Social: The patient was evaluated for NAT and received a normal ophtho examination & skeletal survey. Initially, there was some concern about the patient's distal R femur but images were re-checked and no fracture was seen. DEPARTMENT OF SOCIAL SERVICES & MEDICAL SOCIAL WORK were consulted. It was determined that the

EXHIBIT 26

Hist. No: 000-545-02-19

family would attend parenting classes and DEPARTMENT OF SOCIAL SERVICES would evaluate the home situation.

Pertinent test results:

1. CT Scan Head (12/5): Thin falx subdural hematoma and right convexity subdural hematoma.
2. CT Scan Head (12/7): Interhemispheric and right convexity blood
3. Skeletal Survey: Negative

Condition at Discharge: Good

Discharge Medications:
None

Instructions given to Patient/Family:

1. Please return in 2 weeks for repeat skeletal survey
2. Please pay close attention to baby and do not leave him alone or unattended
3. Please monitor for changes in mental status, increasing lethargy, onset of vomiting.

Follow-up Care:
Dr. Praxton at Sunshine Pediatrics (Primary Care)
LCH X-Ray for Skeletal Survey on 12/18/09

Thank you for allowing CHIPS to care for your patient at Levine Children's Hospital. If you need additional information, you may access the patient's electronic medical record or call the Pediatric Referral Line at 704-446-KIDS and ask to speak with the CHIPS attending for Team A.

D: ERIC SCHENFELD, MD/R
T: 12/08/2009 3:18 P es6
cc:

Routing
Pediatric Physician Link: Please route to all providers listed in Follow-up Care. In addition, route to ??

EXHIBIT

"27"

1 A Shaken --
2 Q -- syndrome?
3 A That's what, yeah, correct.
4 Q Okay, okay. Is the absence of -- of a retinal
5 hemorrhage, does that rule out that there is
6 nonaccidental trauma?
7 A No, it wouldn't. I mean, it -- it just --
8 there's no way to --
9 Q Okay.
10 A No, it wouldn't, because, I mean, obviously,
11 there would be, obviously, different ways to
12 traumatize a child. I mean, it -- I mean, you
13 could shake them here and it -- and their head
14 might be stable for some reason. So they
15 might not have retinal hemorrhages. But that
16 obviously would be nonaccidental trauma.
17 Q All right. Well, have you ever had an
18 occasion to evaluate a child who -- who was
19 suspected of suffering from nonaccidental
20 trauma and had subdural hematomas but did not
21 have retinal hemorrhages?
22 A To my recollection, I've seen children who've
23 had subdural hematomas who didn't have retinal
24 hemorrhages. But I don't know. And again, it
25 -- it -- it comes with, you know, my role is

EXHIBIT 27

EXHIBIT

"28"

PLAINTIFF'S EXHIBIT 28

Attachment F

Child Abuse and Neglect Algorithm

Medical team identifies child in whom abuse or neglect is suspected

Consult CHS Clinical Care Management Social Worker to assist with assessment process

Is the suspicion of abuse or neglect confirmed

Yes

Report case to:
- County DSS in which child resides
- Law Enforcement Agency where the incident occurred, if indicated

Complete SCAN Form including diagrams

Investigating agencies to provide evidentiary photography and maintain chain of custody

Refer to Administrative Policy # PR 120.06 "Consent for Treatment" if parent guardian, custodian, or caretaker refuses to authorize necessary medical treatment for child

For patients with evidence of acute multi-system injury consult CMC Trauma Service at 1-800-421-9195. If patient is at CMC contact Trauma Chief at pager 1888 or the Trauma Attending at pager 1899

Consult LCH Pediatrics at 704-446-5437 or 1-888-279-5437 for assistance with medical management For patients at LCH contact the Hospitalist at pager 7415

Refer to Child Maltreatment Clinical Practice Guidelines (policy PR110.03) for assistance with medical management

When medically cleared, do not discharge child until disposition has been determined by medical-social worker and DSS

No

Continue with Medical Management Plan
Provide safety education as indicated

EXHIBIT 28

EXHIBIT

"29"

Order No.	Time	Date	Room	Entered By	Priority	Scan / Faxed Complete	Initials / Signature
	0350	12-5-01	8015-01		☐ STAT ☐ Normal		

Admit to CHIPS A Attg: Gall Intern: Schenfeld x 1360
Dx: ALTE
Condition: Good wt = 6.1 kg
Vitals: Q4°
Activity: Ast tolerated Falls precaution Reflux precautions
Allergies: NKDA
Nursing: ABD monitors Q4° neuro checks Strict I/O's Daily wt
Diet: PO ad lib on demand
IVF: ~~Ad lib~~ NS bolus 120 ml IV x 1 now then D5 ¼ NS @ 25 ml/hr
Add 20 mEq KCl/L ⊽ 1st void
Meds: None
Labs: Viral DFA

CHART CHECK
Call _____ Time _____
MD Signature _____

A. Rf MD
Renfrow
x 6423

Order No.	Time	Date	Room	Entered By	Priority	Scan / Faxed Complete	Initials / Signature
	0821	12-5-01			☐ STAT ☐ Normal		

STAT CT Head w/o contrast R/o bleed

A. Rf MD
Renfrow
x 6423

ABBREVIATIONS	
USE	
units	U
International units	IU
X mg (Never use a trailing zero)	X.0 mg
X.X mg (Always use a leading zero)	0.X mg
daily	QD
every other day	QOD
Morphine	MS MSO4
Magnesium Sulfate	MgSO4

Carolinas HealthCare System
PHYSICIAN'S ORDERS

4844 (9/05)

PATIENT LABEL
09339-00393
C000546-02-19 LV:
[redacted]
ATT PRY: 98026 CMCED,PEDB
12/05/09 02:14A DOB: [redacted] TQC

PLAINTIFF'S EXHIBIT
DATE 9/8/04

Rainey-Carduff v. Carolinas Medical Center
000030

EXHIBIT 29

General Progress Note

Carolinas Medical Center

Printed: Monday, DEC 07, 2009, 12:03 by COURTLANDT , CHERYL DENISE MD

RM: 8023, SPC [redacted] 2 MO (DOB: [redacted] M MRN: 5450219

Attending: CHIPS , TEAM A Code Status: None Specified Reason for Admission: ALTE

Service: PED - Pediatrics

Allergies: , No known allergies

Vitals	Temp	BP	Pulse	RR	SpO2	FIO2/O2
12/07 10:00	----	66/54	154	28	98	RA
12/07 06:30	----	-----	132	29	---	RA
12/07 05:30	----	-----	115	23	---	RA
12/07 04:30	----	-----	134	24	---	RA
12/07 03:30	----	-----	130	25	---	RA

Date	Wt(kg)	Wt(lb)
12/07	6.0	13
12/07	6.0	13
12/06	6.0	13
12/05	6.1	13
12/05	6.1	13

	Recorded	Input	Output	Balance
12/07	7a-3p	120	121	-1
	3p-11p	---	---	---
	11p-7a	---	---	---
	24 Total	120	121	-1
12/06	7a-3p	270	203	67
	3p-11p	150	193	-43
	11p-7a	270	109	161
	24 Total	690	505	185

24 Hr Tmax: 97.9 at 12/06 19:30
36 Hr Tmax: 97.9 at 12/06 19:30

Vitals Signs are the last 5 in the past 48 hours.
Weights display the last 5 within 7 days.
Clinical Wt: 12/07 6.1 kg 13 lb

Active Inpatient Medications:

Continuous Infusions:

Labs: Results shown are for the past 8 hours

12/07 0639

HCT	28	L	MCH	28		RBC	3.34	L
HGB	9.4	L	MCV	84		RDW	13.6	
			Platelet	523	H	WBC	10.1	

Notes:

Date:

Time:

Reds attending note
pt clinically well
but AF, slightly bulging ?HCT
MS-unchanged
eye exam ⊖ NAT ⊕
Child Coordinating/MSW involved
parents updated

HEENT - large
appearing head
open and centre
AF - very full
Lungs - clear
Heart - RR on Abd - benign
Impression - Subdural
hematoma
normal MS @ this time
Plan: repeat CT 20 AF

Signature: CCourtlandt MD 12/7/2007 10 AM Date/Time

Physician Progress Note

333

☐ ADMITTING
☒ ATTENDING
☐ CONSULT

ACCT: 0933900393 MRN: 0005450219
[redacted] ✓ W MSW about D/C planning
ATT PHY: CHIPS , TEAM A
12/05/09 04:45A DOB: [redacted] 2 MO
✓ DSS referral status

PAGE BREAK!

Rainey-Carduff v. Carolinas Medical Center
000038

Physician Progress Note

Carolinas Medical Center

Printed: Tuesday, DEC 08, 2009, 07:08 by SCHENFELD , BRIC MD

RM: 8023, 8PC [redacted] 2 MO (DOB: [redacted] M MRN: 0005450219 Acct: 09339-00393

CURRENT PROBLEMS:

NOTES/PLAN: Peds attending note

extensive conversation w/ Dr. Morgan-Glenn, MSW regarding case

no etiology of sub dural received

NAT (w/ Flu ⊖) eye exam ⊖

no story explaining an explanation

HEENT - AF ↓

Lungs - clear

Heart - RR ⊖m

Abd - benign.

Impression - Sub-dural hematoma

? etiology

NAT ⊖ @ this time

Plan - DSS to follow family w/ home visits, supervision

cleared by MSW

Repeat skeletal survey 2 weeks

Flu w/ PCP

ATTENDING NOTES:

Signature: [signature] 12/8/2009 12m

Date/Time

Physician Progress Note

☐ ADMITTING

☒ ATTENDING

☐ CONSULT

* 3 3 3 *

ACCT: 0933900393 MRN: 0005450219

[redacted]

ATT PHY: CHEPS , TEAM A

12/05/09 04:48A DOB: [redacted] 2 MO

Rainey-Carduff v. Carolinas Medical Center

000033

EXHIBIT

"30"

PLAINTIFF'S EXHIBIT 12 PAGE 9/27/12

DATE	TIME	RECORD PROGRESS OF CASE, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT.
12/7/09	1845	X-cover
		Pt w/ stable CT. DSS / SW ok to D/C w/ Mom & Dad. Will D/C home, F/U w/ Dr. Baxter (PCP). Will D/W NSG & follow their recs
12.8.09		Neurosurg —
	0815	Alerts easily. AF soft. HC 42.5 Ok à mo. to discharge
		MS Lanahan

ABBREVIATIONS	
USE	DO NOT USE
Units	u or U
International units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	qd, QD
every other day	qod, QOD
Morphine	MS or MSO4
Magnesium Sulfate	MSO4

Carolinas HealthCare System
PROGRESS RECORD
(3/07)

09339-00393
C000548-02-19
[redacted]
ATT PHY: 66247 CHIPS,TEAM A
12/05/09 DOB: [redacted] M 2M

CMC (12.05.09) 0033

EXHIBIT 30

EXHIBIT

"31"

Order No.	Time	Date	Room	Entered By	Priority ☐ STAT ☐ Normal	Scan / Faxed Complete	Initials / Signature
	2200	12/7/09	8039				

- D/C monitors while awake
- resume while sleeping (spot v O_2)

TO Dr Melissa Smith / S Harrison RN

DATE: ____ TIME: ____

12/8/09 0732 MD SIGNATURE: ____

24° chart RN

12° chart check S RN / RN

Order No.	Time	Date	Room	Entered By	Priority ☐ STAT ☐ Normal	Scan / Faxed Complete	Initials / Signature
	0930	12/8/09					

1. D/c home c̄ parents ī MSW approval
2. Activity as tolerated
3. meds see med rec
4. f/u please schedule PMD ī Sunshine Peds ī ī Cardiology in 2wks for NAT (from admission) 12/1 Dw 12/11 (12/4/09)
5. D/c i.v.

Appointment 704-512-2060 12-18-09 9:00 am Levine Children's Hospital

805-980-7337 Appointment Dec 11, 2009 at 8:45am

Ima Nugent #4789

FAXED 1147

1045817 confirmation #

fax no 704-446-4100

ABBREVIATIONS	
USE	DO NOT USE
units	u or U
international units	IU
X mg (Never use a trailing zero)	X.0 mg
0.X mg (Always use a leading zero)	.X mg
daily	QD
every other day	QOD
Morphine	MS or MSO_4
Magnesium Sulfate	$MgSO_4$

Carolinas HealthCare System
PHYSICIAN'S ORDERS

PATIENT LABEL

09339-00393
C000545-02-19
[redacted]
ATT-RHY: 60247 CHIPS,TEAM A
12/05/09 DOB: [redacted]

"444"

Rainey-Carduff v. Carolinas Medical Center
4844 (3/99) 000018

PLAINTIFF'S EXHIBIT 13 FOR ID 9/27/11

EXHIBIT 31

EXHIBIT

"32"

PLAINTIFF'S EXHIBIT 35 YAC 9/5/15

PROGRESS NOTE -- CHILDREN'S HOSPITAL INPATIENT SERVICE HD#

DATE: TIME: Please see attached record of vital signs, medications, and laboratory data.

Patient / Family concerns:

General Appearance:

HEENT — *Describe abnormalities as needed*
- ☒ normocephalic
- ☐ head abnormal
- ☐ conjunctival injection / icterus
- ☐ PERRL
- ☐ pupils abnormal / photophobia
- ☐ ears normal
- ☐ external canal abnl (R / L)
- ☐ TM abnormal (R / L)
- ☐ nasal mucosa normal
- ☐ mucosa abnormal
- ☐ oropharynx normal
- ☐ dry mucosa ☐ ulcers / vesicles
- ☐ pharyngeal erythema
- fontanelle flat
- ☐ tonsillar enlargement / exudate

NECK / LYMPH NODES
- ☒ supple / no masses
- ☐
- ☒ no node enlargement
- ☐ enlarged cervical / axillary / inguinal

LUNGS / CHEST
- ☐ stridor
- ☒ no respiratory distress
- ☐ retractions / accessory muscle use
- ☒ breath sounds normal
- ☐ prolonged exhalation
- ☐ decreased air movement
- ☐ wheezing / crackles / rhonchi
- ☒ normal shape
- ☐ pectus (carinatum / excavatum)

CARDIOVASCULAR
- ☒ regular rate & rhythm
- ☐ abnormal rate & rhythm
- ☒ heart sounds normal
- ☐ murmur grade ___/6 systolic/diastolic
- ☐ strong peripheral pulses
- ☐ pulses abnormal
- ☒ capillary refill normal
- ☐ delayed

GI (Abdomen) — *Describe abnormalities as needed*
- ☒ nontender
- ☐ tenderness / rebound / guarding
- ☒ nondistended
- ☐ distended
- ☒ no organomegaly
- ☐ hepatomegaly / splenomegaly / mass
- ☐ normal bowel sounds
- ☐ decreased / hyperactive
- ☐ anus/rectum normal
- ☐ abnormal

GU
- ☐ external genitalia nl
- ☐ erythema / discharge / swelling / tender

EXTREMITIES
- ☒ no swelling
- ☐ swelling
- ☒ nontender
- ☐ tenderness
- ☒ ROM normal
- ☐ abnormal

SKIN
- ☒ normal inspection
- ☐ cyanosis / pallor / jaundice
- ☒ warm, dry, nl palpation
- ☐ cool / diaphoresis
- ☒ no rash
- ☐ rash

NEUROLOGIC / PSYCHIATRIC
- ☐ mental status normal
- ☐ lethargic / confused / agitated
- ☒ cranial nerves II-XII nl
- ☐ CN deficit
- ☐ muscle strength/tone nl
- ☐ weakness
- ☐ sensation normal
- ☐ sensory deficit
- ☐ DTRs normal
- ☐ abnormal DTR
- ☐ cerebellar function nl
- ☐ ataxia
- ☐ age-appropriate gait
- ☐ gait abnormal
- ☐ mood & affect normal
- ☐ abnormal

ADDITIONAL FINDINGS:

ASSESSMENT / PLAN:

2 mo old ♂ w/ hx of limp ALTE & increased irritability here w/ (R) SDH concerning for NAT & (-) w/up thus far.

(1) Neuro: stable - fontanelle soft today

(2) CV/Resp: stable

(3) Social: (P) SW ok, pt ok to d/c.
- f/u 2wks NAT
- parenting class
- home visit

☐ Discussed impression and plan with patient/family; questions answered and understanding of plan demonstrated.

SIGN / PRINT NAME [signature] PAGER 6782

ATTENDING NOTE: I have examined & discussed this patient with Dr. ___. I agree with the findings / plan as documented in the resident's note.

SIGN / PRINT NAME _____ DATE _____ TIME _____

Carolinas HealthCare System
PROGRESS RECORD

NAME
MR #

EXHIBIT 32

CMC (12.05.09) 0031

EXHIBIT

"33"

Page 1

Transcript of Recording
Labeled "Christa DSS"
Dated 1/19/2010
- - - - - - - - - - - - - -

Transcribed by: Audrey S. Beebe,
Southern Reporting, Inc.

Page 2

LIEUTENANT MILLER: Sheriff's office. Miller.
CHRISTA: Yes. Can I speak with Lieutenant Miller, please?
LIEUTENANT MILLER: This is him.
CHRISTA: Hey. I didn't catch your -- I was making sure it was you. How are you doing this morning? This is Christa.
LIEUTENANT MILLER: Hey. I'm doing good. How you doing?
CHRISTA: I'm doing pretty good. Did you get the news from the hospital?
LIEUTENANT MILLER: Unh-unh.
CHRISTA: The parents have decided to kind of just withdraw all care and just let the baby die. That's what Mom and the grandmother have decided.
LIEUTENANT MILLER: Well, did they not take it off the life support yesterday?
CHRISTA: Yeah, they did. They took him off the ventilator. So basically they're just -- they got the do-not-resuscitate in place.
LIEUTENANT MILLER: Okay.
CHRISTA: And based on the information that the doctors have given them that the baby is not going to get any better and he's going to be brain dead, they have decided to proceed that way. And the hospital

Page 3

has contacted us to let us know that, which we were made aware of that yesterday. But I knew since it was a holiday no one had contacted you.
LIEUTENANT MILLER: Right. Well, I appreciate that.
CHRISTA: Okay. I just had a couple of questions for you, Lieutenant Miller. Do you think we can schedule a meeting possibly? You and Amanda Carter so that we can sit down with Yvonne and Phyllis and myself and staff the case?
LIEUTENANT MILLER: Yeah.
CHRISTA: Just to make sure we're on the same page?
LIEUTENANT MILLER: Yeah.
CHRISTA: What about -- do you think Thursday? Can you check with Amanda and see? Or what do y'all have scheduled for Thursday?
LIEUTENANT MILLER: We've got a SART meeting at nine o'clock that morning.
CHRISTA: Yeah, I know. Lynn's going to that, so I'm aware of that. And we've got a meeting from 9:30 to 11:30, but we were looking at possibly the afternoon.
LIEUTENANT MILLER: Two o'clock?
CHRISTA: Two o'clock will be good.
LIEUTENANT MILLER: Okay. I better put that --
CHRISTA: And you think Amanda -- that might work in her

Page 4

schedule?
LIEUTENANT MILLER: Yeah. I'll get it in there unless there's a problem.
CHRISTA: Okay. Do you -- are you going to -- y'all want us to come there? You want to come here? How you want to do it?
LIEUTENANT MILLER: If y'all don't mind coming here, we've got -- probably got more room.
CHRISTA: That's fine. We can come there if you would like. Because it's going to be our attorney, our director, myself, program coordinator, and Devondra.
LIEUTENANT MILLER: Okay. Yeah. There's --
CHRISTA: So --
LIEUTENANT MILLER: I don't see a problem with that.
CHRISTA: Okay. So we can come over there. Also, did you ever check in that file to see the date on that info that I faxed you? You remember when I faxed you that dictation?
LIEUTENANT MILLER: Yeah. Hold on. I got it right here in front of me.
CHRISTA: I just want to get the date that you received the referral. I just want to make sure that --
LIEUTENANT MILLER: The 17th.
CHRISTA: The 17th?

EXHIBIT 33

Page 5

1 LIEUTENANT MILLER: 12/17/09.
2 CHRISTA: And then that was the day that I faxed you the
3 dictation?
4 LIEUTENANT MILLER: Yep.
5 CHRISTA: Okay. Because I remember us talking. It was
6 in the afternoon. Do you have a time on that? I
7 know it was two or three o'clock, it seemed like.
8 LIEUTENANT MILLER: One of them -- the one that you sent
9 me came at 1604, which would've been 4:04.
10 CHRISTA: Okay.
11 LIEUTENANT MILLER: And the other one was sent after
12 hours on the 16th.
13 CHRISTA: The -- her referral?
14 LIEUTENANT MILLER: Yeah. It came in at almost seven
15 o'clock on the 16th.
16 CHRISTA: Okay. That's what I was thinking. Those are
17 the --
18 LIEUTENANT MILLER: Yeah.
19 CHRISTA: That's about the times that I had that I was
20 thinking. Because she -- she doesn't have the --
21 the fax cover sheet in her case file no longer that
22 -- where I faxed you the dictation. So I --
23 LIEUTENANT MILLER: Uh-huh.
24 CHRISTA: -- figured you would have it, so I just wanted
25 to get that from you.

Page 6

1 On the day that you got the referral from me,
2 I remember us talking about it. Did you ever call
3 the hospital and verify any of what I told you? Or
4 did you -- because I had faxed you over everything
5 that they had told me.
6 LIEUTENANT MILLER: No. I didn't -- I didn't feel like
7 I needed to do that.
8 CHRISTA: Okay. I -- I -- I didn't think --
9 LIEUTENANT MILLER: You've never --
10 CHRISTA: I -- they --
11 LIEUTENANT MILLER: You've never told me anything wrong
12 so far.
13 CHRISTA: I know.
14 LIEUTENANT MILLER: Why would I do that?
15 CHRISTA: I -- no. They just asked me that, and I told
16 them I did not think so because I had faxed over
17 all of that information.
18 LIEUTENANT MILLER: Yeah.
19 CHRISTA: Okay. And it wasn't until the second report
20 that you guys actually went out and met with them
21 because we --
22 LIEUTENANT MILLER: Right.
23 CHRISTA: -- didn't have any concerns at the initial
24 report.
25 LIEUTENANT MILLER: That's what -- you know, and that's

Page 7

1 why -- you know, after all that talking to
2 everybody, there was no concerns. You know, and
3 the -- and the thing was set up to do the in-home
4 -- you know, the parenting counseling.
5 CHRISTA: Yeah. And I --
6 LIEUTENANT MILLER: So that's why I didn't -- you know,
7 there was no more. I said -- you know, I'm -- to
8 me that would've been slapping you in the face and
9 calling you a liar and you don't know what you're
10 doing, you know?
11 CHRISTA: Oh, I know.
12 LIEUTENANT MILLER: And I just -- I just -- that was my
13 thoughts at that time, and that's, you know, still
14 what I believe, that, you know, I don't think at
15 that time we had a problem.
16 CHRISTA: Okay.
17 LIEUTENANT MILLER: You know, and that -- because I -- I
18 -- I -- I believed what you said, and I know you
19 believed what you told me. So --
20 CHRISTA: Oh, I did.
21 LIEUTENANT MILLER: You know, we can't -- nobody has a
22 crystal ball around here so --
23 CHRISTA: I wish we did. It would make our jobs a lot
24 easier, wouldn't it?
25 LIEUTENANT MILLER: They wouldn't need very many of us.

Page 8

1 Well, we don't --
2 CHRISTA: We might not have a job if we had a crystal
3 ball, huh?
4 LIEUTENANT MILLER: All we'd need is one person with a
5 crystal ball and the other one to chase it down,
6 so --
7 CHRISTA: Uh-huh.
8 LIEUTENANT MILLER: But, no, I just -- that was -- that
9 was my beliefs and --
10 CHRISTA: Yeah. What about Kayla? Are y'all -- are
11 y'all still investigating her? She just acts so
12 suspicious, Lieutenant Miller.
13 LIEUTENANT MILLER: We're not through. We're not
14 through with this at all.
15 CHRISTA: Okay.
16 LIEUTENANT MILLER: No. We're not through with this at
17 all. We just -- we're -- what we've done is we
18 took -- taking a step back to let her go on and do
19 what she needs to do as far as the child goes. But
20 once -- once everything's said and done, she's
21 going to come back into the picture.
22 CHRISTA: Because she probably thinks she's out of it.
23 LIEUTENANT MILLER: Right. I don't -- like I say, I
24 don't know what part, if any, she has in it, but
25 she's just --

Page 9

1 CHRISTA: She just is --
2 LIEUTENANT MILLER: -- she's just kind of weird-acting.
3 CHRISTA: And -- you know, and the -- then when they
4 took -- I know the hospital -- this had come from
5 the supervisor that was on call. The hospital had
6 said, when they took the baby off of the
7 ventilator, the baby gasped for air. And Mom was
8 in the room, and she didn't really seem to be -- I
9 mean, she's just kind of emotionless when it comes
10 to a lot of things. And she's just very immature.
11 I know that she's young, but she had -- I know she
12 made that statement to you about the big -- big
13 jail or the little jail.
14 LIEUTENANT MILLER: Yeah. You know, I'm sitting there
15 going, Where -- where is this coming from and why
16 are you even here?
17 CHRISTA: Yeah, I know. And she was -- and that's the
18 thing. Because we had come -- when we went to the
19 hospital, we're like, "Where is she?" And she's
20 out running around dealing with Michael, and she's
21 not -- I mean, she seems to be putting him before
22 her child.
23 LIEUTENANT MILLER: Right.
24 CHRISTA: Yeah. And did he ever admit to shaking the
25 baby in December?

Page 10

1 LIEUTENANT MILLER: No. He -- he said that didn't --
2 there wasn't anything -- nothing like that done,
3 because I went back and talked to him. And he said
4 that he didn't do -- there was nothing, and nobody
5 could figure out what was wrong with him, other
6 than him having a cold and a sore throat.
7 CHRISTA: But he didn't -- he didn't indicate that he
8 had done anything --
9 LIEUTENANT MILLER: Unh-unh. No.
10 CHRISTA: -- to the baby in December?
11 Did y'all give -- y'all gave him a polygraph,
12 didn't you?
13 LIEUTENANT MILLER: Yeah.
14 CHRISTA: And when -- did you ask him that -- was that
15 question asked to him about --
16 LIEUTENANT MILLER: We did -- the only thing that we
17 worked on him was with the --
18 CHRISTA: I know y'all were just trying to get him --
19 LIEUTENANT MILLER: -- current -- the current one, yeah.
20 CHRISTA: Y'all were just trying to get him to
21 confess --
22 LIEUTENANT MILLER: Right.
23 CHRISTA: -- as quickly as possible. I know.
24 LIEUTENANT MILLER: Yeah. We got them. We got -- you
25 know, he told us the truth. He told us a couple

Page 11

1 stories to start off with, but he told us the truth
2 at the end.
3 CHRISTA: At the end?
4 LIEUTENANT MILLER: Yeah.
5 CHRISTA: So the polygraph indicated that he was --
6 LIEUTENANT MILLER: -- deceptive.
7 CHRISTA: Yeah. Okay.
8 LIEUTENANT MILLER: But we didn't bring up any -- there
9 was nothing done about the -- the December stuff.
10 Again, because that -- see, even -- even then that
11 had not figured into my -- that had not even come
12 back to -- in my realm of thinking --
13 CHRISTA: Oh, I know.
14 LIEUTENANT MILLER: -- as far as the December stuff
15 because as -- talking with y'all, I had cleared
16 that out of my head as far as -- because Lola even
17 said, "Oh. This is the one that we had the report
18 on back in December." She had to ring my bell on
19 it, because I did not remember it because, once I
20 had talked to y'all, that was said and done. That
21 was -- that was a problem that was being, you know,
22 taken care of. So I didn't even --
23 CHRISTA: Yeah. I didn't either. I mean, it's kind of
24 a shock that any of this really happened because I
25 never had any indication, and I'm all about taking

Page 12

1 babies and relatively placing babies. But the
2 hospital just wasn't -- they weren't giving us any
3 indication that they -- they had any real concerns.
4 LIEUTENANT MILLER: And all --
5 CHRISTA: You know, all the scans were negative and all
6 -- you know, all those things that would indicate
7 that the baby had been shaken. They didn't have
8 any --
9 LIEUTENANT MILLER: And they had taken this child to
10 four different doctors, and the only thing they
11 came up with was a cold and a sore throat.
12 CHRISTA: Uh-huh.
13 LIEUTENANT MILLER: You know, and it's not --
14 CHRISTA: And I -- I have all their medical records, and
15 it is consistent. They did take the -- the child
16 to the doctors when they said that they had taken
17 the child to the doctors.
18 LIEUTENANT MILLER: Right. I don't -- along with that
19 and what y'all had told me and all that kind of
20 stuff, I just -- you know, I felt comfortable with
21 it, you know.
22 CHRISTA: Yeah.
23 LIEUTENANT MILLER: Maybe I shouldn't have, but --
24 CHRISTA: Well, I mean --
25 LIEUTENANT MILLER: -- I was comfortable.

Page 13

1 CHRISTA: Now you -- now it's easy to say that, but
2 then, based on the -- because, you know, I had
3 staffed it with our legal department, and we just
4 didn't really have enough to do -- you know,
5 proceed any further with doing a removal or
6 anything.
7 LIEUTENANT MILLER: Right.
8 CHRISTA: So, yeah --
9 LIEUTENANT MILLER: Well, I think --
10 CHRISTA: -- it's unfortunate.
11 LIEUTENANT MILLER: -- it goes back to -- I -- I didn't
12 even see that stuff that the grandfather or whoever
13 it was said, but, you know, they need to -- people
14 need to realize, you need to blame the person who
15 did it.
16 CHRISTA: Yeah. And they're not --
17 LIEUTENANT MILLER: And he --
18 CHRISTA: The grandparents -- and I saw their little
19 thing on Channel 9 News and all of that, but the
20 thing is they need to think -- they had all these
21 concerns and all these -- they have seen these
22 mysterious bruises, and then he even went as far as
23 to photograph a bruise on the child at some point.
24 See, we weren't made aware of any of that.
25 LIEUTENANT MILLER: Right.

Page 14

1 CHRISTA: See, they should've been calling and making a
2 report to us, had they -- had they had concerns.
3 See, we could've looked at it a lot differently,
4 and they were saying how, you know, that they were
5 acting suspicious and Kayla had called one day and
6 made a remark that she was going to lose it, to
7 come get the baby. And -- yeah. So they didn't
8 tell any of this to us until afterwards.
9 LIEUTENANT MILLER: Yeah. And, see, none of that came
10 to light till after the -- the --
11 CHRISTA: Yeah.
12 LIEUTENANT MILLER: -- actual shaking of the baby that
13 we know about.
14 CHRISTA: Yeah, I know.
15 LIEUTENANT MILLER: So --
16 CHRISTA: And --
17 LIEUTENANT MILLER: And, see, you're telling me stuff,
18 again, that they're saying that I hadn't even heard
19 yet.
20 CHRISTA: Yeah.
21 LIEUTENANT MILLER: So --
22 CHRISTA: Yeah. We'll -- we'll -- we'll get all that
23 out there whenever we staff the case on Thursday
24 because I just want -- I just want everybody to be
25 on the same page, and let's just do a staffing and

Page 15

1 that way y'all can -- y'all have all the
2 information that we have and we have what you have.
3 And if you need copies of medical records or
4 anything that we have, we can certainly provide you
5 with all of those because the baby has beaucoup
6 medical records.
7 LIEUTENANT MILLER: Okay.
8 CHRISTA: Tons. So you said two o'clock on Thursday
9 afternoon?
10 LIEUTENANT MILLER: That'll be fine with me.
11 CHRISTA: Okay.
12 LIEUTENANT MILLER: Y'all just come over here and holler
13 for me. We'll meet in one of our conference rooms.
14 CHRISTA: Okay. Thank you so much, Lieutenant Miller.
15 LIEUTENANT MILLER: Oh, and before you get off the
16 phone, I called you earlier. I don't know if you
17 were returning my call.
18 CHRISTA: No. I hadn't -- I hadn't checked any voice
19 mails.
20 LIEUTENANT MILLER: Yeah. I'd left you one. The other
21 one that I wanted to ask you about was this Kylie
22 Sanders.
23 CHRISTA: Yeah.
24 LIEUTENANT MILLER: What's the deal with it? Have --
25 has she seen the SANE nurse yet?

Page 16

1 CHRISTA: Okay. She went to the pediatric doctor, and
2 basically the pediatric -- see, okay, when I talked
3 with Gina -- remember, you put me in contact with
4 Gina?
5 LIEUTENANT MILLER: Right.
6 CHRISTA: Gina consulted with Dr. Olga Rosa in Columbia.
7 LIEUTENANT MILLER: Right.
8 CHRISTA: And their recommendation was that -- the
9 general practitioner who had seen Kylie at Clover
10 Family Medicine couldn't determine whether or not
11 the child had a skin tag or had an anal wart.
12 LIEUTENANT MILLER: Right.
13 CHRISTA: And basically, Gina and Dr. Olga Rosa said
14 that the doctor should've been able to determine
15 that.
16 LIEUTENANT MILLER: Right.
17 CHRISTA: And their recommendation was that the child be
18 seen by a pediatrician. So the foster parent took
19 the child to Rock Hill Pediatrics, because I had
20 Clover Family Medicine do a referral. And I have
21 around here somewhere -- and I will send it to you.
22 Oh, here it is. I'm going to send it to you --
23 where she saw the doctor on the 21st and they
24 determined that the child had anal fissures that
25 had been -- that were healed and they really

Page 17

1 couldn't determine whether or not the child had
2 been sexually abused or not. We have this case
3 down to staff it with David tomorrow to see what
4 direction we're going to take.
5 LIEUTENANT MILLER: Uh-huh.
6 CHRISTA: They just couldn't -- they just -- they can't
7 really tell you that -- just the child had anal
8 fissures, and it healed. And it could be sexual
9 abuse; it could not. They -- it could've went
10 either way.
11 LIEUTENANT MILLER: Right.
12 CHRISTA: And this child, obviously, based on her age,
13 she's nonverbal --
14 LIEUTENANT MILLER: Right.
15 CHRISTA: -- so we're not able to get any, you know,
16 additional information. So we're going to be
17 staffing it tomorrow. We've actually already
18 indicated our case, but it wasn't for sexual abuse.
19 But if they determine that we need to take a new
20 report and do a new investigation in regards to
21 these anal fissures, we -- we certainly will. And
22 I'll -- and I'm going to give it back to Devondra
23 if -- if that happens. But basically, that's all
24 the information that I have at this time. And
25 after I staff it tomorrow, I can give you -- and

Page 18

1 see what all foster care -- you know, if they have
2 any additional information, I will call you
3 tomorrow.
4 LIEUTENANT MILLER: Okay.
5 CHRISTA: I'll go ahead and fax this -- do you want me
6 to go ahead and fax the visit over to you?
7 LIEUTENANT MILLER: Yeah. Go ahead and do that, and
8 then let me know what y'all come out of -- what the
9 outcome is from y'all's, because if it's not going
10 to be -- you know, if -- if -- again, like, say we
11 can't interview the child and we have to go off of
12 doctors' records but they can't tell us either, the
13 only person that would be able to tell us would be
14 the grandfather, if he is the one that actually did
15 it.
16 CHRISTA: And I don't know --
17 LIEUTENANT MILLER: And I don't know --
18 CHRISTA: And I'm going to tell you this child has been
19 in contact with so many people, Lieutenant Miller,
20 it'd be really hard to determine who -- who would
21 even be a perpetrator. And that's the unfortunate
22 thing is -- is her age.
23 LIEUTENANT MILLER: Who is the grandfather?
24 CHRISTA: I would have to get that information from
25 Devondra.

Page 19

1 LIEUTENANT MILLER: Well, because -- is he a sex
2 offender or --
3 CHRISTA: I think so, yeah. From my -- from my
4 knowledge, he is a registered sex offender.
5 LIEUTENANT MILLER: Okay. Just get all that information
6 for me so I can follow through on this side and see
7 what we need to do and --
8 CHRISTA: I sure will.
9 LIEUTENANT MILLER: -- we'll --
10 CHRISTA: As soon as I get this Carduff squared away,
11 just give me -- I -- I should have this to you in
12 about an hour.
13 LIEUTENANT MILLER: Okay. That'll be great.
14 CHRISTA: Okay?
15 LIEUTENANT MILLER: Thank you, ma'am.
16 CHRISTA: All right. You're welcome.
17 LIEUTENANT MILLER: Bye-bye.
18 CHRISTA: Bye-bye.
19 (End of recording.)
20 (*This transcript may contain quoted material.
21 Such material is reproduced as read or quoted
22 by the speaker.)
23 (**Certificate accompanies sealed original
24 only.)
25

EXHIBIT

"34"

Action Date:	1/11/2010	**Action Time:**		**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	7:27 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:27:15 1/12/2010

Collateral Contact-Social Worker-Yvette Case manager inquired about Medical Records for the minor child [redacted] Case manager was informed she would need a release of information from the parents and they would not be able to give medical records to her tonight-they stop giving medical records at a certain thing-Case manager would need to get in contact with the hospital in the morning regarding receiving medical records.

Actions:

Face to Face with child/client

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545390 - Lythgoe, Kayla - 06/12/1990 (E)

Action Date:	1/11/2010	**Action Time:**		**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	7:31 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:31:12 1/12/2010

Safety plan- Owen has acute bleed in the head, actively seizing, multiple bruises chest, arm, thighs, and legs, actively seizing not a good sign-2nd injury much more serious this time. Kayla and Michael will have No unsupervised contact with [redacted] will not go home with Kayla and Michael. Levine's Children's Hospital will contact York County Department of Social Services when minor child to be released/discharged. Both parents will comply with safety plan-failure will result in court intervention. Case manager Hill will follow up with ALL parties and request records, etc. Parents never arrived back at the hospital-Case manager spoke with Charlotte Williams regarding the safety plan and hospital staff-A copy of the safety plan was placed in Owen's file.

Actions:

Telephone Contact

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545398 - [redacted] - 09/09/2009 (E)

EXHIBIT

"35"

HRC690-R01 South Carolina Department of Social Services 5/12/2010 4:47 PM

Case Dictation

Case ID - 0001113743

Actions:

Face to Face with Adult (To Review Treatment Plan)
Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545398 - [redacted] - 09/09/2009 (E)

Action Date:	1/29/2010	**Action Time:**	6:30 PM	**Time Spent:**	2.00
Input Date:	2/4/2010	**Input Time:**	9:59 AM	**Worker:**	Golden, Joacquinia

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 9:59:03 2/4/2010

GW Golden made face to face contact with Kayla Lythgoe and her child ([redacted] at levine children hospital room# 8 at 1000 blythe blvd charlotte, nc. 704-381-8840 or 704-3812000. CW Golden discuss and explained the safety plan that ycdss had put into place for the safety of the child [redacted] The safety plan states. Kayla Lythgoe will ensure that all immediate family including but not limited to the following: herself, grandparents and step grandparents, uncles, aunts and cousins are to have supervised contact with [redacted] This safety plan is effective 1/29/10. Kayla lythgoe is responsible for ensuring compliance with safety plan. DSS will monitor safety plan through follow-up with levine children's hospital. Kayla Lythgoe stated that she understood the safety plan she sign and dated the safety plan. GW Golden gave kayla Lythgoe a copy also GW Golden left copy a copy of the safety plan with Levine children's Hospital staff. CW Golden also observed inside the room was a nursing assistance (sitter) whom stated her responsiblilty was to sit inside the room with the child and mother at all times she was awaiting for someone to relieve her. Kayla Lythgoe mother was also inside the room.CW Golden submitted the YCDSS copy of the safety plan to supervisor krista Hinnant.

PM 8:58:45 2/17/2010

Note: Only Action Code Face to Face with Child/Client should be selected.

Actions:

Initial Face to Face With Child/Client

Recipients:

0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545398 - [redacted] - 09/09/2009 (E)

Action Date:	1/29/2010	**Action Time:**	6:30 PM	**Time Spent:**	0.50
Input Date:	2/17/2010	**Input Time:**	9:00 PM	**Worker:**	Golden, Joacquinia

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 9:00:54 2/17/2010

Summary of Protective Action:Kayla Lythgoe will ensure that all immediate family including but not limited to the following: herself, grandparents and step grandparents, uncles, aunts and cousins are to have supervised contact with [redacted] This safety plan is effective 1/29/10. Kayla lythgoe is responsible for ensuring compliance with safety plan. DSS will monitor safety plan through follow-up with levine children's hospital. Kayla Lythgoe stated that she understood the safety plan she sign and dated the safety plan.

Actions:

Collateral Contact

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)
0001545390 - Lythgoe, Kayla - 06/12/1990 (E)
0001545391 - Williams, Charlotte - 03/01/1969 (E)
0001545398 - [redacted] - 09/09/2009 (E)

Action Date:	1/29/2010	**Action Time:**	3:35 PM	**Time Spent:**	0.25
Input Date:	1/29/2010	**Input Time:**	4:26 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 4:26:31 1/29/2010

Supervisor spoke again with SW Linda Brown at Levine's. Linda stated that they can keep a sitter in the room for the time-being, but that are not sure that they will be able to keep a sitter until February 12th, when [redacted] is discharged. Supervisor read safety plan to SW Linda Brown that states that "All immediate and extended family including but not limited to the following: parents, grandparents and stepgrandparents, uncles, aunts and cousins are to have supervised contact with [redacted] Levines Children's Hospital and/or their designee is reponsible for ensuring compliance with this safety plan." Supervisor faxed a copy to SW Linda and Linda confirmed receipt of the safety plan. Supervisor asked Linda if it is possible for her to have the family sign the safety plan and she stated that she would not feel comfortable doing that. Supervisor asked Linda if someone from the hospital would sign the safety plan since they would be indentified as the protector and would be reponsible for ensuring compliance with the safety plan. Linda stated that she was not sure and that she would consult with the nurse in charge and get back with Supervisor.

Actions:

Staffing With Supervisor

Recipients:

0001545389 - Carduff, Michael - 03/17/1991 (E)