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

Appellate Case No. 2017-001367

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

v.

South Carolina Department of
Social Services.....Respondent.

Initial Brief of Appellant

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STATEMENT OF ISSUE ON APPEAL

The trial court erred in granting summary judgment in favor of DSS because it used an incorrect standard for determining gross negligence and consequently failed to recognize genuine issues of material fact evidencing DSS's lack of slight care.

STATEMENT OF THE CASE

Appellant Elizabeth Hope Rainey, as the appointed guardian *ad litem* to Owen C., filed this action alleging negligence and gross negligence against Respondent South Carolina Department of Social Services (DSS), along with Carolinas Medical Center's Levine Children's Hospital (Levine), York County Sheriff Bruce Bryant, and the York County Sheriff's Office. Through the course of prior motions and an appeal, DSS became the sole defendant. On remand, DSS filed a motion for summary judgment and a hearing was held before the Honorable S. Jackson Kimball. The trial court granted DSS's motion. Appellant filed a motion to alter or amend and for reconsideration, which was denied following a hearing. Appellant timely filed a notice of appeal.

STATEMENT OF FACTS

Michael Carduff and Kayla Lythgoe, who were eighteen and nineteen respectively, lived together with their three-month-old son, Owen C. On December 4, 2009, Owen C. "got real stiff," turned red, and appeared to be "straining," so his parents brought him to the emergency room at Piedmont Medical Center ("PMC"). When he arrived, staff noted he was "lethargic, not responsive and [they]thought he was dead." (Exhibit 1, York County DSS 00143). After triage and an examination, Owen C. was transferred to Levine, a children's hospital, in Charlotte because of an "apparent life threatening event." (Exhibit 2, Levine History & Physical, CMC0059-0062). Owen C. was admitted to Levine during the morning of December 5th and medical tests were performed to determine the cause of his physiological symptoms. The next day a CT scan revealed a subdural hematoma—bleeding on his brain. This raised concerns that Owen C.'s injuries were non-accidental. These concerns were magnified when neither parent could explain how the injury occurred. Levine, through its social workers, notified DSS that an infant with two subdural hematomas had been admitted and the hospital had concerns that the child's injuries were non-accidental. (Exhibit 3, Hinnant Deposition at 109 (agreeing DSS was called because Levine's staff had concerns that Owen C.'s injury was non-accidental); Exhibit 4, Dictation Notes at 253–255).

By way of background and context, when there is a suspension of child abuse a variety of procedural safeguards, statutorily proscribed by the Legislature and dictated by internal policies/procedures, are triggered to protect the child. As explained herein, these safeguards mobilize interdisciplinary reliance between the reporting hospital, DSS, and law enforcement to act, blending a range of duties and responsibilities to ensure the welfare of the child.

When a hospital suspects child abuse, its employees must notify DSS. S.C. Code Ann. § 63-7-310; (Sutherland Deposition at 39). Once DSS has received a report of suspected abuse, an

on-call case worker is assigned by the on-call supervisor to initiate a preliminary investigation within twenty-four hours. (Hinnant Deposition at 14-16); S.C. Code Ann. § 63-7-640; (CPS Manual 0013-14). This investigation includes a safety assessment to determine if the child is safe and "if parental behavior has caused harm or placed the child at substantial risk of harm." (CPS Manual 007; CPS Manual 0014-15; 0052 (outlining the purpose and procedure for an investigation)); *see also* S.C. Code Ann. § 63-7-20; § 63-7-620; § 63-7-920. This initial information is gathered through an in-person interview with the child, parents, and other collateral sources including nurses, doctors, and hospital social workers to discuss the facts surrounding the report. (CPS Manual 0016; 0055-56; Hinnant Deposition at 24–25). When meeting with the parents, the case worker has the parents enter an initial safety plan to be used to "control immediate present danger safety threats." CPS manual 0057; S.C. Code Ann. § 63-7-920. Additionally, law enforcement is required to be notified within twenty-four hours when there is suspected child abuse. S.C. Code Ann. § 63-7-980; (CPS Manual 0013; CPS Manual 0052-53; Hinnant Deposition at 87; Sutherland Deposition at 32–35; Hill Deposition at 27–28).

After the initial encounter, the case is staffed/assigned to the case's permanent case worker and supervisor, often separate from those addressing the emergency event, who will handle the ongoing investigation. The purpose of the first meeting after transfer is to determine the risk of harm the child faces and what further action needs to be taken. (CPS Manual 0057-59). Notably, when a child is in a hospital setting, as here, DSS must determine whether the child requires placement in emergency custody following a medical discharge or if the child can be released to the parents during DSS's ongoing investigation. This decision is uniquely separate from a health care provider's decision. (Sutherland Deposition at 40). In sum, DSS is required to make its own decision on the safety of the child. *Id.*

Over the course of the investigation, which spans forty-five-days, the case continues to be staffed by the assigned caseworker and supervisor, along with the county attorney. (Hinnant Deposition at 17-19; Sutherland Deposition at 15). During staffing meetings, discussions and decisions are made, relying on the social worker's notes, medical records, and law enforcement reports. *Id.* at 22-23, 61.

Returning to the specifics of this case, in response to the notification of suspected child abuse, the on-call case worker Chandra Tyler went to Levine. (Exhibit 4, Dictation Notes, at 253-255). She spoke with Michael and Kayla, along with the maternal grandparents. *Id.* Ms. Tyler had Michael and Kayla enter an initial safety plan, and she provided the parents with a DSS brochure outlining their rights. *Id.*; (Safety Plan & Brochure).[1]

The next day, December 7th, the case was transferred from the on-call case worker, Ms. Tyler, and her supervisor, Lola Sutherland, to the staff assessment caseworker assigned to the case, Dirvondra Hill, and her supervisor, Krista Hinnant. *Id.* at 252. Ms. Hinnant went to Levine to meet with Owen C.'s family and any available collateral sources (nurses and Levine's social workers). At that time, she learned the CT scan showed "non-accidental trauma" and was told Owen C. suffered from a "non-accidental" injury. *Id.* at 251. Ms. Hinnant remained in contact with Levine's social workers throughout the day, and one social worker informed her that "the hospital cannot determine whether the injuries are accidental or nonaccidental" and "the hospital still cannot rule out any trauma." *Id.* at 250. The social worker also shared that the treating physician "stated that she cannot determine if the injuries are an accident or not at this point." *Id.*

[1] Pursuant to the safety plan, the parents were not to remove Owen C. from the hospital until both Levine and DSS made their respective decisions. (Safety Plan; Dictation Notes at 253).

Moreover, the social worker explained an overarching concern was the "parents are t[w]o young parents and the hospital mostly has concerns for lack of supervision." *Id.*

Later in the afternoon, on December 7th, Ms. Hinnant, on behalf of DSS, informed Levine that the agency decided Owen C. could go home with his parents. *Id.* at 249. Ms. Hinnant explained DSS would follow up with a home assessment that same day. *Id.* at 249. Additionally, she noted the following action items needed to occur: obtaining medical records from Levine, PMC, and Owen C's pediatrician; contacting law enforcement; following up with Owen C.'s doctor; and speaking with Owen C.'s grandmother. *Id.* Around 3:30 p.m. Owen C. was medically discharged from Levine. At the time of discharge, child abuse had not been ruled out and there was no explanation for the cause of Owen C.'s life threatening injuries.

Following Owen C.'s medical discharge and release to his parents, DSS allowed ten days to pass without contact with Owen C.'s family and fourteen days without contact with Owen C. (Dictation, at p. 248, 252-253). Although Ms. Hill attempted unannounced visits on three occasions there was no contact or further investigation into Owen C.'s safety. *Id.* During the first encounter with a family member on December 17th, ten days following release, Ms. Hill briefly spoke to Kayla and confirmed the family would meet with her on December 21st. At the home visit on December 21st, Ms. Hill learned for the first time who lived in Owen C's home and made DSS's first contact with Owen C. since the hospital. (Hill Deposition at 19-20).

In violation of the statutory requirement to contact law enforcement within twenty-four hours, DSS waited ten days before notifying law enforcement of the initial report of child abuse. (Hill deposition at 29; Dictation Notes at 246; Exhibit 6, DSS Letter Requesting Law Enforcement Involvement). In response to the abuse notification, Lieutenant Miller called Ms. Hinnant, explaining the information provided by DSS was inadequate to understand the circumstances,

especially given the delay in contact by DSS. (Exhibit 6, DSS Letter Requesting Law Enforcement; Transcript of Call at 6). Lieutenant Miller repeatedly expressed his frustration with DSS's lack of notice, stating "I guess the thing that bugs me the most is getting it ten days after."[2] *Id.* at 7. In response, Ms. Hinnant explained she asked Ms. Hill to make contact and "fussed at her" about the delay. *Id.* at 7. Moreover, she stated, "[Ms. Hill] should've made it as soon as she got the report when we staffed it from on-call," on December 7th. *Id.* Ms. Hinnant admitted to Lieutenant Miller that she knew the call had not been made within the twenty-four hours, as required by their policy, as well as statute. *Id.* Ms. Hinnant described the inaction as "unacceptable" because an injury like Owen C.'s requires reporting per DSS's policy, and characterized this failure as a "big problem." *Id.* at 8, 10, 14. Further she misrepresented the hospital statements by telling Lieutenant Miller the hospital didn't have "any suspicions" of child abuse. *Id.* at 12.[3]

A few weeks later, Owen C. was left alone with Michael. He shook Owen C. and dropped him down a set of concrete stairs. Hours later, Michael and Kayla noticed Owen C. was in distress. Instead of crying, Owen C. was moaning and twitching all over.

When Owen C. arrived at Levine for a second time, he was diagnosed with another subdural hematoma, in addition to retinal hemorrhaging, and persistent seizures. Owen C. had

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[2] *See also, Id.* at 9, (explaining his immediate reaction to receiving DSS's paper worked included "What the hell?" regarding the delay, and an automatic concern that "*we've got some body that's done hurt this child*") (emphasis added).

[3] In addition to speaking with Ms. Hinnant, Lieutenant Miller expressed his frustration with DSS's failure to contact law enforcement to Ms. Sutherland . (Exhibit 15). He explained DSS's failure "just infuriates the living hell out of me . . . ." Ms. Sutherland responded that she could not explain why law enforcement had not been notified for ten days. *Id.* at 5-6. Notably during this call Ms. Sutherland stated "nobody has an answer as to why or how that child was injured." *Id.* at 7. In sum, Lieutenant Miller repeatedly expressed his concerns about DSS's failure to call and the fact that no one could address how Owen C. was harmed resulting in such severe injuries. *Id.* at 14-15, 18.

suffered an anoxic brain injury, causing blindness and deafness. Owen C. received morphine for his pain and was eventually placed in hospice care. After a period of hospice care, Owen C.'s medical outlook began to improve. He was released from hospice but has suffered serious, permanent injuries. He is permanently blind and deaf, and will never be able to walk. Michael plead guilty to child abuse and is currently in prison. Exhibit 8, News Articles.

Appellant, as Owen C.'s guardian *ad litem*, filed the current suit alleging negligence and gross negligence against Levine, DSS, York County Sheriff Bruce Bryant, and the York County Sheriff's Office.[4] (Complaint). DSS answered the Complaint with a qualified general denial in addition to affirmative defenses including: lack of foreseeability of a third party, South Carolina Tort Claims Act ("TCA") defenses under section 15-78-60(1), (2), (3), (4), (5), (12), (20), (23) and (25) of the South Carolina Code, and a bar to punitive damages pursuant section 15-78-120(b) of the South Carolina Code. (Answer). DSS then filed a motion for summary judgment. (DSS Motion and Memorandum in Support). In support of its motion, DSS argued there were no genuine issues of material fact and it was not grossly negligent because the agency demonstrated at least slight care in responding to the intake and conducting the investigation. *Id.* DSS relied on the fact that its employees went to Levine in less than three hours following the initial call, along with Ms. Hill's attempted home visits after Owen C.'s release to his parents. *Id.*

[4] Levine moved for summary judgment and a hearing was held before the Honorable S. Jackson Kimball. Judge Kimball issued an order granting Levine summary judgment on the basis that Levine did not have a duty to retain Owen C. in its custody when DSS determined whether he would be released/discharged to Michael and Kayla. Appellant immediately appealed and the grant of summary judgment was upheld by the Court of Appeals on the basis that the duty to investigate and ensure Owen C.'s safety belonged solely to DSS. *Rainey v. Charlotte-Mecklenburg Hosp. Auth.*, No. 2015-UP-209, 2015 WL 1880212 (S.C. Ct. App. Apr. 22, 2015). Additionally, in 2013 Defendants Sheriff Bruce Bryant and the York County Sheriff's Office were dismissed from this action through a consent order.

In response, Appellant submitted a memorandum in opposition to summary judgment arguing DSS oversimplified the duty owed to Owen C. and that any evidence of slight care was inadequate to satisfy summary judgment pursuant to *Bass v. South Carolina Department of Social Services*, 414 S.C. 558, 571, 780 S.E.2d 252, 258-59 (2015), and a determination of gross negligence belonged to a jury. (Memo in Opposition). Additionally, Appellant argued there were genuine issues of material fact in which there was more than a scintilla of evidence to demonstrate DSS failed to exercise slight care. Specifically, Appellant argued three areas where genuine issues of material fact existed: DSS's investigation prior to Owen C.'s release to his parents; DSS's investigation and assessment following Owen C.'s release; and DSS's failure to contact and communicate with law enforcement in violation of state law.[5]

In support of Appellant's position, a variety of evidence was submitted including the affidavit of George Savarese, Ph.D., LCSW, an expert in clinical social work and social policy analysis, in which he opined that DSS failed "to conduct an appropriate and independent psychosocial assessment in order to identify, explore and comprehend the specifics of the risk for

[5] Specifically, Appellant argued as to the investigation prior to Owen C.'s release there were genuine issues of material fact as to whether DSS had the requisite facts to make a determination regarding risk of abuse and harm to Owen C. at the time of his release; whether DSS allowed a medical discharge to abrogate its own duty to protect Owen C. and rely solely on Levine; and whether Ms. Hinnant fundamentally appreciated the information shared by Levine. As to the investigation and assessment following Owen C.'s release, Appellant contended genuine issues of material fact included whether Ms. Hill exercised slight care when she had no contact with the family for ten days and no contact with Owen C. for fourteen days; whether Ms. Hill exercised slight care when there is no evidence to suggest she attempted to request medical records or contact collateral sources to further the investigation with no contact with Owen C. or his family; and whether Ms. Hinnant exercised slight care as a supervisor of this case when she knew Ms. Hill had no contact with Owen C. As to contact and communication with law enforcement, Appellant argued there were at least two genuine issues of material fact related to whether DSS exercised slight care in fulfilling its duty to thoroughly investigate Owen C.'s case when law enforcement was not contacted within twenty-four hours as required by law and Ms. Hinnant was aware of this breach. Appellant's Memorandum in Opposition.

child abuse and re-injury related to [Owen C.]." (Affidavit at 2). Dr. Savarese also found that DSS failed to "protect a vulnerable child from abuse and neglect." *Id.* He further offered a causation opinion, stating in his opinion "to a reasonable degree of professional certainty that the actions or inactions of the employees and/or agents of [DSS] . . . . contributed to the injuries and damages of Owen [C.]." *Id.*

A hearing was held on the motion. A majority of the discussion between counsel and the trial court involved the role of *Bass*, and two of Appellant's genuine issues of material fact, with Appellant relying on her memorandum for the remaining alleged genuine issues. (March 13, 2017 Transcript); (Tr. 63-65). The genuine issues discussed at length were: (1) whether DSS had the requisite facts to make a determination regarding the risk of abuse and harm to Owen C. at the time of his release, and (2) whether DSS exercised slight care in fulfilling its duty to thoroughly investigate Owen C.'s case when law enforcement was not contacted within twenty-four hours as required by law. (Tr. 41-61). The crux of Appellant's argument was that by failing to properly investigate the known factors of child abuse, which includes contacting law enforcement to gain pertinent information, DSS failed to exercise slight care when it blindly returned the child into the hands of his abuser without the requisite knowledge to assess the risk of harm. (Tr. 41-55). Further Appellant suggested that DSS's action could not amount to slight care given the circumstances as to each undertaking. DSS disagreed stating that under South Carolina case law the agency exercised slight care based on the evidence. (Tr. at 4, 5).

The trial court held DSS could not be found to be grossly negligent based on the entire record. (Order at 7). In dismissing Appellant's argument that DSS failed to contact law enforcement, the court in a footnote stated that even though DSS did not meet its statutory mandate

to contact law enforcement within twenty-four hours, "that failure was not the proximate cause of the tragic injury" to the child. (Order at 7, fn. 2).

Appellant timely filed a motion to alter or amend and for reconsideration. (Motion to Alter or Amend and for Reconsideration). Appellant contended the trial court failed to recognize DSS has a duty of slight care in each undertaking. *Id.* at 1-6. Specifically, Appellant took issue with the trial court's holding that slight care is based on the "entire record," which Appellant suggested was contradicted by *Bass*. *Id.* Appellant also argued the cases relied on by the trial court were distinguishable because the Supreme Court has consistently held a child's age is relative because the age dictates the level of care and that DSS has a unique statutory duty to protect children. *Id.* Appellant renewed prior arguments that there were genuine issues of material fact and more than a mere scintilla of evidence was submitted to survive summary judgment. *Id.* Moreover, Appellant argued the trial court's finding as to law enforcement misapplied the summary judgment standard and incorrectly addressed proximate cause. *Id.*

The trial court held a hearing, and Appellant's motion was denied in a Form 4 order. (May 18, 2017 Hearing Transcript; Form 4 order). This appeal followed.

STANDARD OF REVIEW

"An appellate court reviews a grant of summary judgment under the same standard applied by the trial court pursuant to Rule 56, SCRCP." *Lanham v. Blue Cross & Blue Shield of S.C., Inc.*, 349 S.C. 356, 361, 563 S.E.2d 331, 333 (2002). 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. In so determining, the trial court is concerned with the existence of evidence, not its weight. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (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).

ARGUMENT

Appellant is entitled to the reversal of summary judgment because the trial court used an incorrect standard for determining gross negligence and consequently failed to recognize genuine issues of material fact evidencing DSS's lack of slight care.

The trial court's grant of summary judgment must be reversed because it failed to apply the proper standard in determining gross negligence. As explained herein, South Carolina law requires DSS to exercise slight care during each phase of its investigation, including the execution of any undertaking prescribed by statute, policies/procedures, or guidelines. The exercise of slight care in one instance does not absolve DSS from liability for the other portions of its investigation as suggested by the trial court's ruling. The trial court's order ignored the applicable case law and oversimplified the standard and relevant care in light of DSS's responsibilities and Owen C.'s age. As a result, DSS has garnered immunity despite genuine issues of material fact, evidence providing more than a mere scintilla of DSS's failure to exercise slight care, and DSS's conceded statutory violation. For these reasons, the grant of summary judgment should be reversed and this matter remanded for a jury trial.

Determining DSS's liability for injuries that occur as a result of its failure to properly carry out its duties begins with the Tort Claims Act, which clarifies DSS "is not liable for a loss resulting from . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity, *except when the responsibility or duty is exercised in a grossly negligent manner.*" S.C. Code Ann. § 15–78–60(25) (emphasis added). Gross negligence "means the absence of care that is necessary under the circumstances." *Bass*, 414 S.C. at 571, 780 S.E.2d at 258-59; *Etheredge v. Richland Sch. Dist. One,* 341 S.C. 307, 310, 534 S.E.2d 275, 277 (2000) ("Gross negligence has also been defined as a relative term, and means the absence of care that is necessary under the

circumstances."). Significantly, slight care must be exercised within each undertaking. *Bass*, 414 S.C. at 571, 780 S.E.2d at 258-59. Thus, the exercise of slight care in one instance does not absolve DSS from liability for other actions or inactions. *Id.* Because a determination of gross negligence, implicates mixed questions of law and fact, encompassing whether there has been an exercise of the care that is necessary, their determination typically rests with the jury. *Faile v. S.C. Dep't of Juvenile Justice,* 350 S.C. 315, 332, 566 S.E.2d 536, 545 (2002); *see also Bass*, 414 S.C. at 571, 780 S.E.2d at 258-59 (holding whether DSS acted with slight care in thoroughly investigating after the initial action was a question for the jury).

The trial court held DSS was entitled to summary judgment because it found that examining the undertaking as a whole, there was evidence of slight care. (Order at 7). Specifically, the trial court's order explains "the issue before the [c]ourt is whether the actions DSS did undertake meet the standard of slight care." (Order at 7). Further, the trial court stated:

> In this case, the summary-judgment-standard requires that DSS demonstrate the absence of a factual issue concerning the exercise of 'slight care.' . . . DSS need only show from the entire record that it met the standard of slight care in this case. Based on the entire record, I conclude that DSS has carried the burden of showing that it exercised slight care in this tragic fact situation.

(Order at 7). Despite case law to the contrary, the trial court concludes that slight care may be satisfied from some evidence of care throughout DSS's overall involvement with a child. This ruling was in error and tainted the trial court's review of the evidence before it.

As noted above, a review of whether DSS has acted with the necessary care for the circumstances requires a distinct inquiry into each undertaking. *See Bass*, 414 S.C. at 571, 780 S.E.2d at 258-59. This analytical framework reflects the statutory scheme in which DSS operates because it is charged not with a single duty, but must act in accord with the carefully articulated responsibilities outlined by our Legislature. As illustrated in this case, where DSS investigates

potential child abuse its obligations are numerous. In addition to being contrary to jurisprudence, it is nonsensical to conclude that the performance of care in any one moment excuses gross negligence elsewhere in the investigation.

Thus, the trial courts reliance on *Clyburn v. Sumter Cty. Sch. Dist. No. 17,* and *Etheredge* was misplaced because those cases involved schools and school districts, not DSS who has numerous and distinct statutory obligations to protect children. 317 S.C. 50, 54, 451 S.E.2d 885, 888 (1994); *see e.g.*, S.C. Code Ann. § 63-7-10 (A)(3) ("State and community agencies have a responsibility to implement prevention programs aimed at identifying high risk families and to provide supportive intervention to reduce occurrence of maltreatment."); S.C. Code Ann. § 63-7-10(B); S.C. Code Ann. § 63-7-20(4), (6), (10), (13) (discussing DSS obligations to children); S.C. Code Ann. § 63-7-960 (same). Unlike schools and school districts, whose primary purposes are to educate children, DSS's expressed responsibility is the safety and welfare of children. Thereby demonstrating that the threshold level of care required by DSS is heightened compared to a school or school district, especially in this case where this Court has previously acknowledged that the duty to ensure Owen C.'s safety belonged solely to DSS. *See Rainey v*, No. 2015-UP-209, 2015 WL 1880212, at *3 (holding the duty to investigate and ensure Owen C.'s safety belonged solely to DSS).

Further, the trial court failed to appreciate the import of those cases, which are generally cited for the proposition that gross negligence is a relative term under the circumstances of each case. *Etheredge,* 341 S.C. at 310, 534 S.E.2d at 277; *see also Bass*, 414 S.C. at 571, 780 S.E.2d at 258-59 (explaining gross negligence "means the absence of care that is necessary under the circumstances"). DSS must cater its actions to the situation it is seeking to address and thus the determination of gross negligence requires a similar appreciation for the surrounding

circumstances. Our courts have consistently acknowledged the importance of a child's age in assessing whether an act rises to the level of slight care given a child's needs. *See Clyburn, Etheredge, & Hollins v. Richland Cnty. School District*, 310 S.C. 486, 427 S.E.2d 654 (1993); *see also* Motion to Alter or Amend and For Reconsideration (providing a full factual discussion of all three cases).[6] Simply put, the meaning of slight care is shaped by the child's age. The trial court nevertheless made a blanket comparison of the slight care required in circumstances involving a high school senior to that of a three-month-old infant. (Order at 6-7).

In this way, the trial court failed to apply the attendant law, which clouded its review of the evidence presented. Although generally correct that "the summary-judgment-standard requires that DSS demonstrate the absence of a factual issue concerning the exercise of 'slight care,'" the trial court failed to appreciate that this inquiry into slight care must be conducted at each undertaking and observed in light of the age of the child being investigated. Reviewing the evidence through the proper lens, the record reflects numerous instances giving rise to material issues of fact on whether DSS was grossly negligent.

Turning first to the investigation prior to Owen C.'s release from the hospital there is ample evidence to raise a genuine issue as to whether DSS properly investigated and had the requisite facts to make a determination of the potential risk of harm in returning Owen C. to his parents.

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[6] Briefly, in *Clyburn*, the Court found the school district was not grossly negligent when it took several actions to prevent a high school senior from being attacked on the bus. 317 S.C. at 54, 451 S.E.2d at 888 In finding slight care, the Court distinguished the high school senior from the eleven-year-old in *Hollins*. *Id.* The Court in *Hollins* held the issue of whether slight care was exercised when sending a note home, as a means of notifying a parent of a bus suspension, with an eleven-year-old was a question for the jury. 310 S.C. at 490, 427 S.E.2d at 656. Both opinions reflect the Court's concern with a child's age as a determinative factor in assessing gross negligence, which was reaffirmed in *Etheredge*. *Etheredge*, 341 S.C. at 311, 534 S.E.2d at 277 ("We took notice of the age difference between the parties and distinguished the steps taken by the administrators in *Clyburn* to control the situation.")

Specifically, Appellant identified DSS's eight child abuse factors[7] to assess potential harm, of which DSS was uninformed on four factors. At the time of Owen C.'s release DSS was unaware of Owen C.'s housing conditions, family structure, community violence, and level of support of the extended family. There is evidence that DSS did not know the family structure or level of support until fourteen days after the release. (Exhibit 5, Hill, at p. 19). Further, in is undisputed that law enforcement was not contacted prior to Owen C's release, and therefore DSS was unaware if there was any domestic or community violence in the family or home. (Exhibit 6, DSS Letter Requesting Law Enforcement Involvement; Exhibit 11, Deposition of Charlotte Williams, p. 12-13 & Sherriff Records, p. 59 (discussing grandmother's prior criminal record and domestic violence charge)); *Id.* p. 27-28 (Michael telling police he was charged with possession of stolen goods sixteen). Each factor represents an increased susceptibility of abuse. Coupled with Owen C.'s non-accidental injury, this failure to determine the factors raises genuine issues whether DSS exercised slight care given Owen C.'s infancy. This lack of investigation and alleged failures by DSS are further supported by the submission of Dr. Savarese's affidavit. (Affidavit at 2). Additionally, evidence demonstrates that Levine had not ruled out child abuse at the time of Owen C.'s release. (Exhibit 13, Deposition of Dr. Cheryl Courtlandt, at p. 45).

The record raises additional questions about whether Ms. Hinnant's exercised slight care in her supervision of this case based on her expressed misrepresentation that there was no suspicion of abuse despite the statements by doctors, nurses, and social workers at the time of Owen C.'s medical discharge. (Exhibit 7, Transcript of Telephone Call between Lt. Miller and Ms. Hinnant,

[7] Factors include: family structure, poverty, substance abuse, poor housing conditions, teenage pregnancy, domestic and community violence, mental illness, and lack of support from extended families and community members. (Exhibit 9, at p. 3–4).

at p. 13). This statement was factually inaccurate and a misrepresentation, and raises serious question about her ability to appreciate the risk of harm.

Next, there is ample evidence to raise a jury question as whether slight care was exercised following Owen C's discharge to his parents. It is undisputed that DSS had no contact with any family member for ten days and no contact with Owen C. for fourteen days. (Hill Deposition at 19). Ms. Hill acknowledged it was her responsibility to follow up with the family and that the only way to investigate Owen C.'s case was to meet with the family. (Hill Deposition at 12, 26, 38). Although the trial court and DSS considered Ms. Hill's attempted contact with the family on three occasions sufficient, a determination of whether that rises to the level of slight care in this circumstance belongs to a jury.

Additionally, there is no evidence that Ms. Hill made further efforts in the investigation and assessment of the alleged abuse beyond the failed attempts at contact. There is no evidence that Ms. Hill requested medical records or contacted collateral sources like doctors, neighbors, family friends, etc. to investigate the alleged abuse. *Id.* at p. 39 (testifying that she could not recall ordering medical records). This is significant because DSS suggests that the failed attempts for a face-to-face meeting in the days following Owen C.'s release are enough to demonstrate slight care. However, pursuant to DSS's policies and deposition testimony submitted by Appellant, Ms. Hill knew she had not gathered any information about Owen C. and made no effort to garner information from any other source. This is in direct contradiction to Ms. Hinnant's list of action items that needed to be completed at the time of Owen C.'s discharge. (Dictation Notes at 251). Moreover, it highlights that no other aspect of investigation or assessment was taking place.

Further, there is evidence Ms. Hinnant knew there was no contact and there is no evidence Ms. Hinnant took any action to address the lack of communication, assessment, and investigation

despite her acknowledged role of DSS. (Transcript of Telephone Call between Lt. Miller and Ms. Hinnant at 13 (informing Lieutenant Miller that Ms. Hill had no contact with Owen C.); Hinnant Deposition, at p. 22 (agreeing the primary client of DSS is the child); *Id.* at p. 22–23 (agreeing the safety of the child is the primary concern that guides child protection efforts); *Id.* at p. 68 (agreeing she had the most contact with Ms. Hill)).

In sum, a reasonable jury could find that allowing a fourteen-day period to lapse without contact for an infant is a failure to exercise slight care especially when the case worker acknowledged meeting with the family was the only means to assess the risk, a DSS supervisor was aware of the lack of contact, and no evidence of other efforts were being made to collect information.

Finally, there can be no question that DSS failed to exercise slight care in reporting suspected child abuse to law enforcement pursuant to the statutory mandate and its own policies and procedures. S.C. Code Ann. §63-7-980; (Exhibit 9, DSS Policy and Procedure at 17). Ms. Hill and Ms. Hinnant both testified that it is DSS's responsibility to contact law enforcement, and Ms. Sutherland stated that a child with a subdural hematoma would require a law enforcement referral within twenty-four hours. (Hill Deposition, at 27-28; Hinnant Deposition at 24; Sutherland Deposition at 33). She further explained that in those types of injuries "we're not the ones to decide." (Sutherland Deposition at 35). This failure to exercise slight care is further supported by Lieutenant Miller's frustration with DSS's failure to contact law enforcement for ten days in his conversations with Ms. Hinnant and Ms. Sutherland. (Transcript of Call at 7-9). Additionally, Ms. Hinnant again acknowledged law enforcement should have been called and it was "unacceptable" and a "big problem" that DSS failed to contact them. *Id.* at p. 8, 10, 14.

To compound its error with this issue and despite the fact causation was never raised by either party, the trial court not only weighed the evidence it incorrectly determined proximate cause on this issue. *See S.C. Prop. & Cas. Guar. Ass'n v. Yensen*, 345 S.C. 512, 518, 548 S.E.2d 880, 883 (Ct. App. 2001); *Anderson*, 477 U.S. 242, 249 (1986) (explaining the trial court is not to weigh the evidence but rather to determine if there is a genuine issue for trial). Specifically, the trial court stated in a footnote:

> One concrete example [Appellant] cites as a violation of the applicable standard of care is the fact that DSS did not notify law enforcement of DSS's involvement in the case, and the investigation of the report made by the hospital within twenty-four hours of notification to DSS. *While DSS failed to carry out this mandate, law enforcement was notified and had an opportunity to investigate the case.* Law enforcement took no action on the case prior to the severe injury of Owen by his father. *Thus, while DSS did not act within the prescribed time to notify law enforcement, that failure was not the proximate cause of the tragic injury to Owen [C.].*

(Order at 7, fn.2) (emphasis added). .

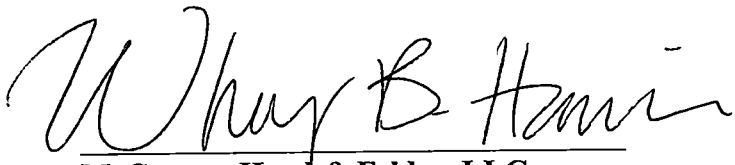
The question of proximate cause is one that should be left to the jury. *See McKnight v. S.C. Dep't of Corr.*, 385 S.C. 380, 387, 684 S.E.2d 566, 569 (Ct. App. 2009) (recognizing that ordinarily, proximate cause is a question for the jury). The trial court's causation holding ignores evidence and the genuine issues raised by Appellant that set forth the multiple ways in which the failure to contact law enforcement connect to DSS's investigation, as explained *supra*. As such, the trial court applies an unfair inference by concluding "law enforcement took no action on the case prior to the severe injury of Owen [C.] by his father" that the known failure by DSS was of no consequence. (Order at 7). That assumption incorrectly disregards DSS's distinct obligation to not only notify law enforcement, but to also evaluate the safety of the child—which requires knowing background information garnered from law enforcement records. Without that information, DSS blindly released Owen C. to his parents. That is a failure to exercise slight care

or at least at minimum creates a genuine issue and a jury question. Moreover, the trial court's assumption as to proximate cause was incorrectly based on hindsight instead of the legal requirement that DSS must exercise slight care as it executes each duty. In direct contradiction to that assumption, Appellant's expert offered a causation opinion, separate from his standard of care opinion, that DSS's action and/or inaction—which includes contacting law enforcement pursuant to the statute—"contributed to the injuries and damages of Owen [C.]. (Savarese Affidavit at 2). This opinion entitles Appellant to survive summary judgment.

In sum, the trial court's disregard of controlling case law blurred the requisite standard and appreciation of the evidence presented. Accordingly, this Court should reverse.

CONCLUSION

Based on the forgoing reasons, the trial court's grant of summary judgment should be reversed and this matter should proceed to trial.



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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

Appellate Case No. 2017-001367

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

v.

South Carolina Department of
Social Services.....Respondent.

PROOF OF SERVICE

The undersigned hereby certifies that on September 13, 2017 she served counsel for Respondent with the *Initial Brief of Appellant and Designation of Matter for the Record on Appeal* in this matter by mailing a copy of the same by United States Mail with first class postage prepaid to the following addresses:

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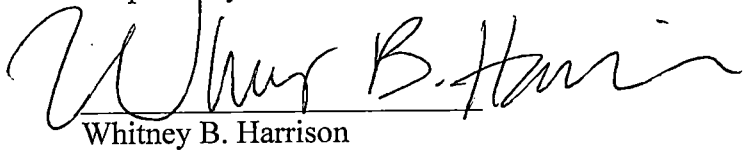
Signature Page to Follow

Respectfully submitted,



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September 13, 2017

Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
P.O. Box 11629
Columbia, SC 29211

RE: *Elizabeth Hope Rainey, v. South Carolina Department of Social Services*
Appellate Case No. 2017-001367

Dear Ms. Kitchings,

Please find enclosed for filing the original and one (1) copy of the *Initial Brief of Appellant* and *Designation of Matter to be included in the Record on Appeal* in regards to this case. I have also enclosed a proof of service. Please return the additional filed copy to me.

Thank you for your attention to this matter. If you need any additional information, please do not hesitate to contact me.

With kind regards, I am

Whitney B. Harrison

Enclosures
cc: Patrick Frawley, Esquire