THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE COURT OF COMMON PLEAS

Honorable G. Thomas Cooper, Jr.

Circuit Court Case No.: 2007-CP-40-03365

Appellant Case No. 2014-001373

Estate of Edward Mims,
Laura M. Cole, Personal Representative,
Appellant,

vs.

The South Carolina Department of Disabilities and Special Needs, Kathi Lacy and Stan Butkus,
Respondents.

SUPPLEMENTAL VOLUME I

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STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

Edward Mims, by and through his legal guardian, Margaret Mims,
Plaintiff

v.

Babcock Center, Inc., Judy Johnson, South Carolina Department of Disabilities and Special Needs, Kathi Lacy and Stanley Butkus,
Defendants

IN THE COURT OF COMMON PLEAS

Civil Action No. 07-CP-40-3365

Plaintiff's Memorandum in Support of Motion for Partial Summary Judgment

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May 29, 2013

Summary of the nature of the case

This is a lawsuit brought by Margaret Mims (Mims), as guardian ad litem for her son, Edward Mims (Edward). The complaint was filed against the Babcock Center, the South Carolina Department of Disabilities and Special Needs and officials of those agencies in 2007 alleging that alleging Edward sustained physical injuries and was mistreated while under their care. The circuit court dismissed the complaint based on issues related to timeliness of service and the application of S.C.Code Ann. § 15-3-20(B) (2005) and the South Carolina Supreme Court reversed and remanded the case for trial in 2012. 732 S.E.2d 395, 299 S.C. 341 (S.C. 2012). Edward files this motion for partial summary judgment on his claim for negligence and gross negligence, with the amount of damages to be determined by the jury at the trial on other issues contained in his amended complaint.

Statement of Facts

Facts related to the DDSN System

The Center for Medicare and Medicaid, commonly referred to as "CMS," is the federal Medicaid agency responsible for the administration and oversight of the Medicaid program. *Pashby v. Delia*, 709 F.3d 307, 314 (4th Cir. 2013). In South Carolina, the Department of Health and Human Services receives all Medicaid funds and it contracts with the South Carolina Department of Disabilities and Special Needs (DDSN) to operate residential programs for persons who have mental retardation. *Doe v. Kidd,* 501 F.3d 348 (4th Cir. 2007). DDSN is the state agency that "has specific authority over the state's treatment and training programs for people with mental retardation and related disabilities." *Doe v. Kidd,* 501 F.3d 348 (4th Cir. 2007). The State Director of DDSN between 1996 and the time of plaintiff's release from

confinement was Stan Butkus. M. 0868. Defendant Kathi Lacy, the Associate State Director of DDSN, also arrived at the agency in 1996. M. 0741. Lacy is responsible for writing policies and assuring that they are followed, including compliance with federal laws. M. 0740 and 0746. She is also responsible for tracking data on abuse and neglect and quality assurance. M. 1424.

Strict federal standards for the operation of ICF/MR facilities are found at 42 C.F.R. 483.800 et. seq. These regulations require the State and its providers to "ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment." 42 C.F.R. 483.420(a)(5). Federal law also requires the State to provide a choice of Medicaid providers. 42 U.S.C. 1396(a)(23) DDSN must determine which home-based setting will meet the recipient's needs and it must "determine the services required because it must insure that it meets the needs of the recipient and that it places the recipient in the least restrictive environment, as required by state and federal law." Doe v. Kidd, supra. See, e.g., *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999); S.C.Code Ann. § 44-20-20 (2006).

In South Carolina Code of Laws Sections 44-20-20 and-375 a statewide network of local boards of disabilities and special needs is established. *Young v. South Carolina Dept. of Disabilities and Special Needs,* 374 S.C. 360, 491, 649 S.E.2d 488 (S.C. 2007). Section 44-20-385 describes the powers and duties of local boards. As the Supreme Court recognized in *Young*, local DSN Boards are:

> [T]he administrative, planning, coordinating, and service delivery body for county disabilities and special needs services funded in whole or in part by state appropriations to the department or funded from other sources under the department's control. It is a body corporate in deed and in law with all the powers incident to corporation....

Id. at 491. DDSN "grandfathered" the Babcock Center as a local DSN Board and it receives financial incentives not granted to other private providers. M. 0936. The SC Legislative Audit

Council Audit of DDSN states at page 3 that Babcock Center was not created by local ordinance, but is recognized as a local DSN Board by DDSN because it existed prior to the statutory establishment of local DSN Boards. M. 0493. In 2003, Babcock Center was the largest provider of these services under contract with DDSN, with an operating budget of more than $41 million. M. 0102. Defendant Judy Johnson is the Executive Director of the Babcock Center. The most restrictive facilities operated by Babcock Center are similar to nursing homes and they are called "ICF/MR" (Intermediate Care Facility/Mental Retardation). *Doe v. Kidd* II, 351. Federal Medicaid law requires that the State give persons who reside in institutions, including ICF/MR's, be provided the option of living in the community. *Olmstead v. L.C.*, 527 U.S. 581 (1999). When DDSN determines that out of home placement is necessary "the client must be evaluated by the department, and the least restrictive level of care possible for the client" must be provided. *Doe v. Kidd II*, Case No. 10-1191 (4th Cir. 2011).

Facts related to Edward Mims.

After providing care for Edward for 27 years at home, his mother voluntarily admitted Edward to the Babcock Center on October 5, 1999 when she became ill. Affidavit of Margaret Mims. M. 2075. Prior to being admitted at Clusters, the Babcock Center assessed Edward and determined that he needs one-on-one supervision:

> To ensure that Edward does not rampage objects in his mouth, he also wonder at night and sleeps very little **this will warrant one-one accountability for Edward.**" BC 4502 to 4511 and 424 to 425.

("BC" refers to Babcock Center records which are attached and are referenced in the Affidavit of Margaret Mims contained at M. 1530. Records with the prefix "M" refer to records contained in the six volumes provided to the Court on May 24, 2013.)

Almost immediately after his admission to Clusters, despite Edward's plan of care requiring one-on-one supervision, he was the victim of frequent "unexplained injuries." Just a month after his admission to Clusters, on November 6, 1999, Edward had "... bruises and scratch marks on his neck." M. 2060 and BC 894. On November 20, 1999, he suffered "a bruise on his right arm." BC 2355. By the next day, there were "scratch marks on the right side of his neck." BC 2354 and 2356. Two months after admission to Clusters, he was "hit in the face with openhanded slap by another resident and treated at emergency room."

Edward's hand was injured, reportedly from another client running over it with a wheelchair, on March 10, 2000. M. 2061. A body audit in April documented "old marks on his knees," which had never before been documented. BC 1804. On May 5, 2000, he suffered injuries to his lip and shoulder with abrasions. "Old bruising" was noted both knees, his hip and his back. But, staff wrote: "*No areas of concern.*" BC 2363. (Emphasis added.) These bruises were still visible on May 26, 2000. BC 1803. They were still present on June 9, 16, and 23 2000. BC 1806 to 1808. By July 4, 2000, records document that Edward's *right* shoulder was bruised, with abrasions. BC 2372. Also in July, Edward was fed tomato juice, despite his chart noting allergy to tomato products. BC 3199. On July 11, 2000, Babcock Center records show a "deep purple bruise on Edward's lower lip"that was still visible on July 16, 2000. BC 3199.

Two days after the injury to Edward's lower lip, he was taken to the emergency room with vomiting and abdominal pain. The July 18 Nurses Notes document "several old bruises noted to left outer aspect of upper arm brownish/yellowish in color, right upper back near shoulder blade right lower back and right side of hip." BC 3199 and 3211. Edward was again taken to the ER for vomiting and dehydration four days later, on July 22, 2000. Exhibit 4 and BC

3197. He was provided with hydration via IV. The next day, Edward returned to the ER because he continued vomiting. Exhibit 4. BC 3194, 3195 and 3197.

On August 4, 2000, a late entry by a nurse reported a "red area left shoulder collar bone..." BC 3192. Two days later, Edward had "two scrapes on back and abrasion on right knee." BC 3192. See also M. 2363. On August 8, 2000, Edward was again admitted to the ER for nausea and vomiting. Exhibit 4. Three days later, Babcock Center records report a "dime size" of "pink tissue" on his right knee and a reddened area on his lower back. BC 3191 and 2066.

Babcock Center Nurses notes from August 13, 2000 report "abrasions on both of client's knees healing ...as are old areas on his back." BC 3191 and 3356. Later on August 13, 2000, Edward was beaten by Babcock Center employee, Carl Anthony. M. 2053. Babcock Center records from the morning after the assault, August 14, 2001, reported that Edward had a "bruised red, right eye lid and under right eye ear, scratches under his neck, rt and left side and on his back." M.2063. See also 2065. By this time, Edward had lost twenty five percent of his body weight since admission in October, 1999. He weighed 109 pounds when he left his mother's home, but his weight had dropped to 81 pounds. BC 4502. Two days after being assaulted, when a nurse tried to examine Edward's wounds, he "started gagging and almost vomited"..." BC 3201. His "eyelid remained dark red and the scratches on neck, sides were also red." BC 3201. These bruises, scratches and scrapes were still visible on August 20 and 27, 2000. BC 3201 and 2367. Edward was again admitted to the ER with nausea and vomiting on August 29, 2000. Exhibit 4.

It is notable that the State Ombudsman was not notified of this assault until 2003. M.

2103 and 2075. In a letter sent to Defendant Judy Johnson, the Ombudsman substantiated that proper supervision had not been provided to Edward and that this abuse should have been reported to the Ombudsman's Office when it occurred. M. 2075 and 2103. The Ombudsman's report states that the incident was reported to law enforcement and that the Babcock Center employee was convicted, but the only evidence of a report being made to law enforcement was that of Edward's mother contacting the Office of the South Carolina Attorney General. M. 2099 to 2101. Anthony was charged on October 4, 2001 and he pled guilty to simple assault and paid a fine of $225. But this conviction came at a high price to Edward and his mother. After Mrs. Mims contacted the Attorney General's Office asking for an investigation, DDSN falsely informed the Probate Court and the court-appointed GAL that Edward was not being cared for at home and that he should be involuntarily committed to the custody of the Babcock Center, preventing his discharge from Clusters. M. 2038 to 2041.

Less than three weeks after Edward was assaulted by Carl Anthony, on September 4, 2000, Edward's mother unsuccessfully attempted to bring him home from Clusters. BC 2368. Nine days later, Carl Anthony was terminated by the Babcock Center on September 13, 2000. The next day, Edward had bruises and scratches all over his body that were not self-inflicted. M. 2098. According to Babcock Center records, Edward suffered "Multiple purple elongated lesion bilateral chest wall, neck, posterior ear, right eye lids and wrist and few scratches also on chest wall." BC 3356. These injuries were unexplained. There is no evidence that these injuries or the termination of Carl Anthony was reported by the Babcock Center to law enforcement. The log maintained by Edward's Babcock Center one-on-one caregiver simply states: "Edward has scratches and bruises," without mentioning the cause of these injuries. The bruises on his back,

upper thigh and knees were so severe, they were still visible a month later, on October 13, 2000. M. 2067.

As if none of this had happened to Edward and although he had lost 28 pounds, nearly a quarter of his body weight, in one year and he had repeatedly been taken to the ER, on October 24, 2000, the Babcock Center annual report states that "Overall, Edward's health has been essentially stable throughout the year." He remained on one-on-one accountability. BC 3220.

Then, on December 2, 2000, Edward was taken to the ER for an x ray of his swollen hand. M.2126. On January 14, 2001, Babcock Center records document that Edward was "Scratched by another client..." BC 1654. The next day, Edward was taken to the ER to evaluate an injury to his right eye. M. 2127. The following day, an unexplained bruise mysteriously appeared inside his right thigh. BC 2059 and 1654.

On January 16, 2001, Edward was noted to have a bruise on his right thigh. BC 885. One week later, on January 27, 2001, Edward's mother reported scratches on his scalp. "Six linear scratches noted over r temporal area of skill, 14 on the r side of the crown, 4 on the l temporal, 1 over the r ear and 1 at inner ___ of r eye." BC 1654. On March 1, 2001, there was a blood clot on the right side of Edward's nose, near his eye. BC 3189. This injury was again examined on March 4, 2001. BC 3189. Four days later, there was an unexplained "scratch right upper leg approx 3" long, thin". BC 3189. This injury still visible on March 10, 2001. BC 3189. Edward's penis was bruised, scratched and bleeding on March 19, 2001. BC 3274. Babcock Center nurses notes dated March 20, 21, 22, 23 and 25. M.2062, 3190.

Babcock Center records dated March 25, 2001, document that Edward suffered unexplained injuries to his scalp, an "old red mark" on right flank. This time, there was a white

blistered area on his forearm and a scratch on his right thigh. The nurse reported "Dark area from old scratch on l side of penis. 3" light scratch on r thigh. Black line in nail bed of r gt toe. Questionable whitish area just to r of center of nape of neck." BC 923. Two days later, it was reported, on March 27, 2001, that Edward was scratched under his right eye and beside his nose by another client. BC 3190 and 3333. This happened again on April 1, 2001. BC 3190.

On April 3, 2001, Mrs. Mims wrote to DDSN requesting that Edward be discharged from the Babcock Center. M. 2075 and 2104. In response, the Babcock Center and DDSN terminated Edward's weekend visits to his mother's home. M. 2076 and BC 3238. Then, on April 16, 2001, DDSN filed a Petition for Judicial Admission to DDSN with the Richland County Probate Court, informing the Court that:

> Edward is fragile and carries diagnosis of cerebral palsy, seizures, hypertension, esophagitis/erosion disease. His mother is in poor health and is unable to care for him since she has limited means and resources.

M. 2105. The abuse of Edward Mims continued unabated at Clusters. Just two days after DDSN filed its Petition for involuntary commitment, on April 18, 2001, Babcock Center records show that Edward had a "laceration to top of head ..dried blood noted to __ also l side several dark red areas noted." BC 1656. Records from April 19, 2001 document "wound to top of head ...some bruising noted." BC 1656.

Edward was examined and assessed for the Probate Court proceedings by Jane McCausland, a masters level DDSN psychologist. M. 2107. Ms. McCausland reported that she reviewed "his working chart as well as interviewed his QMRP, Mr. Kevin Wise." She determined that Edward was:

> a 29 year old Caucasian gentleman who carries diagnoses of Profound Mental Retardation, cerebral palsy, hypertension, a seizure disorder, esophagitis/erosion disease,

> pica, and, additionally, he is self-abusive. Because he has only one kidney, his water intake must be monitored to prevent toxicity. He is currently on a number of medications which require close monitoring as well...*He is nonverbal and assumed a fetal position during my interview with him.* All attempts to obtain any response from him were unsuccessful. (Emphasis added.)

M. 2107. Her report states that: "Mr. Mims has made some progress since he was admitted in 1999" and that "he appeared to be well cared for." Id. Ms. McCausland determined that Edward "continues to need physical care and habilitation for services such as those provided by SCDDSN." M. 2108. She advised the Court that Edward should "remain in a facility where such service needs can be assured" and that he was receiving one-on-one supervision:

> Because of Mr. Mims' significant medical problems, self-injurious behavior, and his very limited ability to care for himself, it would not be in the best interest of Mr. Mims for him to be left unattended. Indeed, he is on one-on-one care at Clusters.

Id.

Mrs. Mims informed the court-appointed GAL that Edward was mistreated at Clusters. M. 2039. But Babcock Center employees at Clusters and legal counsel for DDSN told Edward's GAL that he was "anxious when he returned to Clusters after his weekend visits at home because he was being abused or neglected by Mrs. Mims..." M. 2040.

Even while DDSN's involuntary commitment Petition was pending in the Probate Court, on May 26, 2001, Babcock Center staff "reported client had scratched self under r eye. Small amount of bruising noted." BC 1657. Exactly one month later, on June 26, 2001, the same date that Edward was committed to the custody of DDSN by the Probate Court, he was found to have "purpleness on elbows." BC 3829.

Mrs. Mims' affidavit corroborates the testimony and affidavit of the GAL: "Employees of the Department of Disabilities and Special Needs told lies about me to the Probate Judge at the 2001 hearing." M. 2076. Mrs. Mims was told by DDSN that if she did not agree to the

involuntary commitment: "they would terminate my weekend visitation with Edward." M. 2076. Mrs. Mims testified in her deposition that: "I was afraid that if I didn't sign this, I wouldn't see Edward again." M. 1538.

In return for Mrs. Mims signing the order of commitment, Edward's visits homes were restored. But he continued to come home "with bruises and other injuries from Clusters." M. 2076. On July 3, 2001, the same date that the Probate Judge signed the order of involuntary commitment, Babcock Center records documented that "Edward has old bruise on his upper arm." BC 3864. On July 8, 2001, "redness on his neck" was documented. BC 3828. The records state "Edward has the same marks redness on his neck. Only redness on neck, no other marks." BC 3828. Then on July 12, 2001, Babcock Center records document: "mark on left upper arm and old marks on back." BC 3863. July 15, 2001 records note that there were still "Red marks on neck." BC 3864. The following day, Edward was "... scratched by another client." The right side of his nose had a 1/4 inch scratch with "blood oozing" BC 1660. By the next day, July 17, 2001, he had a "red bruise on back." BC 3837. Two days later, there was a "Mark on side of nose mark on his back." BC 3831. On August 19, 2001, there was a "yellowish color on left side of breast and right." BC 3571. These "yellow spots" around both breasts were again reported on August 21, 2001, with old bruises. BC 1661.

On September 3, 2001: "Edward slipped while being given a shower." BC 3799 and 1661. The accident report stated that Edward fell on floor of the shower and "hit his behind." BC 3796 and 1662. Two weeks later, a leg injury was "investigated" by Babcock Center staff, who "explained" the injury as being "Caused by socks and/or shoes." BC 3798.

On October 3, 2001, the SC Attorney General obtained an arrest warrant for the arrest of

Carl Anthony. The Attorney General's Office affidavit stated that "**Carl Anthony did knowingly and willfully strike or hit Edward Mims about the head.**" But, Anthony was allowed to plead guilty to the misdemeanor of simple assault and he was fined $225. No action had been taken by Babcock Center or SCDDSN to attempt to prosecute Anthony. Mrs. Mims herself persisted in prosecuting case through SC Attorney General's Office and the arrest warrant was not issued for more than a year after beating. M. 2076. On November 13, 2001, Mrs. Mims wrote to Attorney General Condon pleading with him to return Edward to her home:

> What happen to Edward Mims now, Edward & my right have been taken away from Edward and I. Please Mr. Condon, let my son come back home. I'm afraid what going to happen to my son at Babcock Center. Edward can't talk but I know my son...Went (sic) he comes home Edward doesn't want to go back with them to Babcock Center. Edward know that I love him and that I will take care of him.

M. 2113.

On December 3, 2001, Edward was taken to Lexington Medical Center where his hand was x rayed because it was swollen. M. 2126. A photograph taken on December 3, 2001 show a red lash mark across his face and on his shoulder. M. 2056 and 2057. Babcock Records noted an "old bruise light yellow in color." BC 3184. Nurses notes indicated that his neck had been scratched. scratch on right side of neck. There was also "bruising r middle finger." BC 3188. Statements from staff on December 2, 3 and 4 deny there being any marks on Edward. BC 1638 to 1643.

Babcock Center records document that Edward was assaulted by another client at the workshop on December 16, 2001. He had a "possible corneal abrasion" which was treated at Lexington Medical Center. BC 3308. The body audit reported "No new mark & bruise on Edward. Red bumps on his top back & right eye is bruise." BC 3778. On December 19, 2001,

there were red marks on his back and above his right eye lid. BC 3234. Two days later, on December 21, 2001, Edward had a scrape on his left hand. BC 3280. In addition, Babcock Center records document "Old blood on his sheet and shirt. Sm dk red scrape noted on l hand." BC 1664 and 4584.

On December 27, 2001, DDSN responded to the letter Mrs. Mims had written to Attorney General Condon, refusing to allow Edward be discharged from the Babcock Center. No alternatives were provided, except to remain at Clusters. Lois Park Mole, DDSN's Director of Government and Community Relations, wrote to Mrs. Mims:

> I understand that Edward has profound mental retardation, cerebral palsy and several other severe and complex medical conditions. **He is medically fragile, takes a number of medications and requires close monitoring and assistance...All parties agreed that Edward's significant special needs and complex medical conditions required more staffing and supervision than any one person could possibly provide.** No one person can do it all to care for Edward.

M. 2117. This letter states: "We understand that you wish it were possible for him to live at home again." Id. DDSN determined that "several different people have to be awake and around him all the time." Id. But the end result was that DDSN determined that "Edward needs to stay at Babcock...We want what's best for him too, and to work with you." M. 2118.

On January 6, 2002, Edward was found to have "a red mark on left side of neck" and he has "red bumps on back." Also, there were red mark on his left arm. BC 3784. The next day, a "3" long old red scratch noted r side of neck" appeared. BC 1664. (Again noted on January 12.) On January 16, 2002, Edward was treated in the emergency room for abrasions and contusions after being beaten with a belt at the Babcock Center. He had "abrasions over entire body on January 24, 2002 and was taken to Lexington Medical Center for evaluation. M. 2128 and 2130.

According to Babcock Center records, Edward had 27 marks noted over his body. Some of the wounds were "red in color," but the wound on his right upper shoulder was "purple in color.." BC 1644 and 1665. Edward was beaten with a belt by another client on January 24, 2002. BC 1644. He had whelps on his back and arms, with marks on his left and right thighs. BC 1644. There is no evidence that this assault was reported to law enforcement.

Two weeks later, records reported that Edward "slipped on some water that was left on floor from where another resident was mopping." BC 1665 and 4562. On February 4, 2002, Babcock Center records report that Edward "fell" but that the injury was "healing well." BC 3185. Four days later, staff reported that Edward injured the back of his head when he hit the floor falling off a chair. BC 4564. Later in February, Edward he was treated at Urgent Care for a contusion of his right hand with "discoloration and bruising on his first and second fingers of his right hand...They are not sure whether he injured it or hit his hand." BC 3275. M. 2131. Nurses notes indicate that "results are from Edward swinging his hands and hit his hand on the door resulting in the bruise." BC 3185. On March 3, 2002, Edward suffered "two long scratches on middle of right side of neck." BC 3792. These scratches were still visible a week later. BC 3186.

On March 20, 2002, Edward was transferred to Kensington ICF/MR and that same month, Dr. Butkus requested that his internal audit department "review several areas of Babcock." M. 0103.

D.T., a resident of Babcock Center's Wire Road ICF/MR, was not taken to the hospital for nearly 12 hours after an employee threw scalding water on him. M. 1920. The injury was not reported to law enforcement until the next day. Id and M. 2040. In May of 2002, another

Babcock Center client at Wire Road ICF/MR was beaten with a belt by a 16 year old, the same perpetrator who beat Edward with a belt. M. 0078. This abuse was reported in an article published in the Wall Street Journal. "Disabled People Find Group Homes Can Be Broke, Too: That Dam Boy Got Me." M. 1982. According to federal surveyors, a 79 year old victim at Wire Road ICF/MR (M. 0075) was raped at the facility by the same teenager on or about June 13, 2002. M. 0079. On July 21, 2002, his finger was broken and Babcock Center records document that he was beating on the walls and saying "I want out of this hell home" and "I pray to Jesus to send me to heaven or hell." M. 0081. The elderly gentleman was admitted to the hospital with an unexplained broken arm on November 18, 2003. M. 0075 to 0077. (Immediate Jeopardy was declared at Wire Road ICF/MR during a federal investigation conducted on December 2, 2003. M. 0088.)

At first, fewer injuries were reported after Edward was moved to Kensington, but problems were again reported in August and November of 2002. BC 1106 and 1107. In December 2002, CMS required the South Carolina Department of Health and Human Services to "investigate allegations that had surfaced concerning neglect, abuse and misuse of funds at the Babcock Center, Incorporated." M. 0100 and 0103. On January 8, 2003, Edward's head was pushed into a coffee table. BC 1104. A week later, Edward was taken to the emergency room where it was reported that he was unable to sleep and was "holding his hands to his eyes" and his blood pressure was high. Exhibit 4 and M. 2132.

Mrs. Mims continued to insist on body audits being conducted when Edward came home on the weekends and when he returned, so as to protect herself and Edward from claims that he was being injured at home. M.2077. The Babcock Center complained that body audits that had

been requested by Mrs. Mims were a violation of Edward's rights. Id.

On February 28, 2003, a CMS report documented that Kensington failed to meet federal requirements for ensuring that allegations of mistreatment, neglect and abuse, as well as injuries from an unknown source, were reported appropriately. M. 0048 to 0062, see pages 0055 to 0056. During this investigation at Kensington, a client was found to have unexplained bruises to both knees, a scraped elbow and hands and a swollen and tender right arm. Id. at 0055. Another client had suffered a patella fracture which resulted from a fight with another client. Although federal regulations required an investigation to be completed within five days, no report was issued for twenty-six days. Id. at 0056. In this report, CMS documented that Kensington failed to provide appropriate behavior supports for one of Edward's house mates who had a history of sexually deviant behavior. Id. at 0058 and 61.

On May 20, 2003, Edward was found to have a "long red scratch mark" which extended from the left side of his mouth to the side of his cheek. BC 1110. He was taken to the emergency room on July 26, 2003. A week later, Edward was hit by another client on the left side of his head at Kensington, the same client who had pushed him into the coffee table. BC 1109. On August 8, 2003, this same client pushed Edward into the wall at the Babcock Center workshop, resulting in a "scrap on his left hand." M. 2068.

On July 6, 2003, a Clusters resident (the campus of six houses where Edward had lived and was beaten with a belt) was found to have "large abrasions/bruises on his chest" that were "caused by a belt or wire looped object" like a fly swatter. Mr. 0158. The client was assigned 1 on 1 supervision at the time the injury occurred, but no one could explain how the injury occurred. Id. An "Investigation of Injury" dated August 8, 2003 reported "scratches on top of left

hand caused by H. 107" from being pushed into a brick wall. M. 2069. This report states that he will be monitored at all times while around this client. Id.

DHHS released its audit of the Babcock Center in October 2003. M. 0100. The audit reported a "lack of policy to define and require the reporting of serious resident-on-resident abuse to external authorities." Id. Allegations of abuse, neglect and exploitation were not reported in compliance with state law and DHHS found that Babcock Center failed to ensure adequate staffing to supervise residents. Id. Corrective action plans were not followed and financial misappropriations were reported. Id. DHHS reported that "The statistical analysis revealed the number of deficiencies and violations from 2000 to the present." M. 0104. DHHS reported that it had paid Babcock Center more than $1 million for empty beds. M. 0111. The audit found that one-on-one supervision for persons assigned consistently being provided. M. 0113. The audit required to have a physician or other qualified individual annually review the need for one-on-one services. M. 0114. Two out of five cases involving abuse and neglect involving insufficient staffing levels and supervision of staff were substantiated. M. 0124.

CMS inspectors arrived at Clusters the following month. On November 4, 2003, while the federal surveyors were in the building, a staff member assigned to provide one-on-one supervision left the client unattended to take four telephone calls in one hour. M. 0158. He told the surveyor "Well, there are a lot of fights." Id. Another client was reported to be assaulted at Clusters because he frequently was "in the wrong place at the wrong time" and "This often times resulted in him being assaulted." M. 0160. The employee reported that "The home had been running on bare minimum staff, and the one on one requirement for two clients residing in that home could not always be maintained." M. 0160. When asked about a client who was being

targeted, the employee reported that "we all fall into the mind trap of saying, oh, that's just [Client #5's name]." At Clusters House B, the facility was understaffed on 20 out of 31 shifts. M. 0162. The allegation that the Babcock Center failed to report and protect clients from repeated beatings was substantiated. M. 0164 to 0167.

Finally, in November of 2003, one of the six buildings in the Clusters campus of horrors was closed when Babcock Center failed to correct deficiencies found by CMS. Immediate Jeopardy was declared by CMS due to Babcock Center failing to protect clients from harm. M. 0064 to 00. These deficiencies cited by CMS included, in particular, Babcock Center's failure to provide one-on-one supervision to clients determined to need that level of supervision. M. 0068. CMS also found that staff at Clusters was not properly trained and that staff had failed to report suspicions of "abuse, neglect, or injury to clients and trends that may be indicative of victimization." M. 0069. That same month, deficiencies were discovered and reported by CMS at another Babcock Center facility, Bruton Smith Group Home. M. 0072.

In December, 2003, CMS determined that Babcock Center's Ida Lane Community Residence was not in compliance with federal standards for participation in the Medicaid program. M. 0084. Immediate Jeopardy was again declared at Wire Road ICF/MR that same month. M. 0088 and 0093 CMS determined that Babcock Center failed to "provide services necessary to prevent physical harm for all clients." M. 0093. On December 9, 2003, CMS reported that Wire Road was "The second Babcock facility to receive a notice of termination." M. 0096.

A 2004 memorandum issued by CMS reported horrific abuse and neglect of Babcock Center clients living at Clusters ICF/MR. M. 0150 to 0163. One client was stabbed in the neck

with a pen and many clients were bitten, one requiring seven stitches. M. 0155. The memo reported a lack of documentation of injuries from an unknown source, including a swollen jaw and ankle and a "big blue bruise" found on a client's foot. M. 0152 and 0152. The memo reported clients being kicked in the mouth by another client, being kicked causing abrasions, and clients hitting and scratching other clients. Many other incidents of other "client-to-client aggression" occurring between November 1, 2002 and November 4, 2003, while the federal surveyors were there. M. 0154. All 29 incidents documented while federal surveyors were at Clusters "resulted in injuries to the victim." One client exhibited 249 physically aggressive incidents, including biting, kicking and pushing other clients. M. 0157. One of these incidents required 8 stitches to close the forehead of the victim. Id. A staff member admitted not reporting an altercation for ten days "because he was scared due to the staff member's position within the residence." Id. Another staff member disclosed on her exit interview a staff member hitting a client with a wooden paper towel holder. M. 0158.

In March of 2004, Defendant Butkus "got a commitment from the Babcock agency, spoke with Ms. Johnson and the Board, to reduce the capacity by 25 percent over three years, because I felt that they had too much on their plate to manage." M. 1421. This reduction was based on trending data "that Kathi Lacy" oversaw, how they were doing in different program areas." M. 1422. On Juy 27, 2004, Edward was taken to the hospital with "ant bites all over." Exhibit 4. The ants were found in his bed. According to Defendant Butkus, this was the "type of thing" that Defendant Kathi Lacy was responsible for being aware of and tracking. M. 1376. Butkus said this event was "problematical." M. 1377. Then, just three days later, Edward suffered a cut on his lower back and he arrived home for his weekend visit with his hair matted. M. 2093. BC 4888.

Babcock Center records state that Edward fell out of his chair and hit his back on an air conditioner. Id.

Less than one month later, Edward's roommate, Billy Cothran, choked at Kensington. M. 2093. Although he was on a mechanically altered diet, chunks of cheese toast were found in his trachea. Id. After his death, CMS declared Immediate Jeopardy again at Kensington on October 13, 2004. M. 2146. CMS found Kensington to be understaffed, staff to be poorly trained and that the Babcock Center failed to thoroughly investigate the death. 0199 and 1983. See also report of survey conducted October 12, 2004 at M. 0211 to 0217. Page M. 0195 contains a review of behavioral data of Mr. Cothran. See page Wall Street Journal article re Billy Cothran. M. 1983. This report documents that he was assaulted by other clients at Kensington "at a rate of 3 to 4 reported attacks per year." M. 0196. The records reviewed included 18 incidents of "mostly unknown cause," including carpet burns, scratches, bruises and a cut above the eye. M. 0196 and 0197. As Mrs. Mims and the mother of "Madison" had done, Mr. Cothran's family attempted to move him out of Babcock Center, but he died at the facility just four days before he was supposed to be moved. *Madison* at 655. M. 1983 and 1987.

On October 28, 2004, Edward was taken to the doctor with "redness around left eye since yesterday morning." Exhibit 4. On November 2, 2004, Edward's doctor noted "Mild bruising" around his left eyelid. Exhibit 4. According to sworn deposition testimony of Defendant Butkus:

> And in the fall of '04, the trend line still was not good for the agency as a whole on quality. So what I did was I met with the Board and said we have to reduce by 50 percent. We have to go from 634 beds to 317 beds in 18 months, and that's what we did.

When inspectors returned to Kensington in November 23, 2004, they found that the facility still did not comply with the Life Safety Code. M. 0215 and 2151. CMS found

Kensington to be in a state of disrepair, with holes in the walls and 22 work orders that had been submitted in September not being completed. M. 0206 and 0207. Defendant Butkus testified that he made a decision to require Babcock Center to downsize by 50% on or about December 15th, 2004. When asked about the Babcock Center ICF/MR facilities being out of compliance, Butkus said "We knew that we were not satisfied with the level of quality at Babcock Center as Babcock Center. Any of the residential programs, we were not satisfied in." M. 1446. Butkus admitted having responsibility for the problems at the Babcock Center and described his decision to downsize Babcock's residential program as "taking action to correct a situation that he didn't think is acceptable." M. 1448. He found the situation at the Babcock Center ICF/MR facilities was "unacceptable." M. 1449.

On January 18, 2005, Carolina Medical Review (CMR) issued its report of investigations of Babcock Center ICF/MR facilities. M. 0209. CMR concluded that:

> In consideration of review findings, CMS cannot provide assurance to DHHS that Babcock Center, Inc. Is meeting the minimal conditions of participation in the Medicaid program as required by federal regulations.

M. 0214. This survey was conducted to follow up on the surveys conducted by CMS during the fourth quarter of 2004. Id. CMR reported "There is no comprehensive set of policies and procedures for the administration of programs and other aspects of business." M. 0210. There was no evidence of follow up on abuse and neglect files. Id. Staff had not been trained as frequently as indicated by administrative staff. Id. Harmful chemicals were found in the ICF/MR facilities "unlocked and accessible to residents throughout the program crating potential hazards within the homes." M. 0212. Approximately half of the facilities were "in need of major repairs..." M. 0212. Home had holes in walls and flooring. Id. Of significance is the finding that

"Residents who had what appeared to be widely disparate care needs were observed, particularly at ...Kensington I and Kensington II..." M. 0213. Homes were being "reclassified without documentation of client needs assessment for appropriate placement and in consideration of fire and safety standards." M. 0213. Sanitation was "compromised throughout the locations..." Id.

The Director of DHHS sent Defendant Johnson a letter stating: "Based on the findings of this limited scope review, I am concerned that the deficiencies noted may be indicative of more pervasive problems at Babcock. Specifically, I am most concerned about the lack of evidence of ongoing active treatment for clients." M. 2153. The Director sent a letter to the Regional Administrator of CMS informing that federal agency that "As a result of the finding in the report, CMR was unable to provide us assurance that Babcock was meeting the conditions of participation as required under the federal regulations." M. 2156.

On March 8, 2005, DHEC cited Kensington for failing to correct deficiencies. M. 2094 and M. 2161. According to CMS, Kensington was decertified on April 29, 2005. M. 2094. The Director of DHHS sent Defendant Johnson a letter informing her that a second follow-up visit to Kensington on April 27, 2005 found that "the facility remained out of substantial compliance with requirements for participation in the Medicaid program and recommended termination effective April 30, 2005. M. 2159. The Director instructed Johnson to provide DHHS plans for resident relocation no later than May 2, 2005. Id. He directed Defendant Johnson to notify all responsible parties via telephone and letter that their Medicaid agreement for Kensington "has been terminated due to your facility's failure to meet the federally mandated Medicaid participation requirements." Id. Johnson was directed to post public notices "in visible areas" throughout Kensington notifying the public that Babcock's Medicaid agreement had been

terminated and "that assistance will be made available for resident transfers to other participating facilities." M. 2160. But that certainly was not true for Edward and his mother's attempts to discharge him continued to be unsuccessful. DHEC also sent a letter to Defendant Johnson informing her that Kensington was found to be out of compliance with federal regulations and that participation in Medicaid was being terminated. M. 2162.

On May 3, 2005, Defendant Johnson sent a letter to families of Kensington residents after calling them on the phone on May 2. She informed families that "We have been directed to begin planning for relocating the residents." M. 2163. Contrary to the repeated findings of CMS, DHEC and DHHS, Johnson informed families that "There are no health, safety or accountability issues involved." Id. That was simply not true.

On May 27, 2005 Edward was found in his room with a 4 cm "gaping laceration" on his penis. M. 2124. He was treated at Lexington Medical Center ER where seven stitches were required to repair the wound. M. 2122. When Edward was examined by the physician in the ER, there was "oozing of blood from the wound." Id. The ER report states "They are uncertain how the wound occurred." Id. According to Defendant Butkus, the responsibility for preserving evidence and reporting the unexplained injury was that of Defendant Johnson. M. 1399. The Babcock Center "critical incident" report states that "Mrs. Mims decided to make a report to the police department." M. 2165. The unnamed officer called Kensington and said that he would follow up "in a few days." M. 2165. As of June 2, 2005, there had been no follow up by the police. Id. But, Defendant Butkus sent a memo to Defendant Johnson on June 1, 2005, five days later, informing her that the Ombudsman and DDSN's medical consultant, Dr. Graeme Johnson would be investigating Edward's injury. M. 2167. Dr. Graeme Johnson arrived on June 2, 2005

and found "a few scalp scratches." He reported that the nurse who examined Edward on the night of the injury did not find blood or tissue under his fingernails," but he did not contact the physician who treated Edward at the ER or the social worker who filed a report with the Ombudsman. M. 2169. Edward was not wearing pants with a zipper and there were no sharp or protruding objects in the area. Id. Dr. Graeme Johnson determined that "it is unlikely that Edward Mim's laceration was due to abusive or negligent management." M. 2170. He determined that "It is an unexpected problem that had no antecedents." Johnson reported "He appeared to be in a caring, supportive situation when the laceration occurred and appropriate care and follow-up had been provided...The evidence I have seen, the notes I have reviewed, and interviews I have conducted, lead me to a conclusion that it is unlikely that Edward Mims's laceration was due to abusive or negligent management." His report does not mention the declarations of Immediate Jeopardy, the public notice that DHHS required Babcock Center to put on the door warning of the termination of the facility's participation in the Medicaid program, or the prior findings that there was a resident with sexually deviant behavior living in the facility.

Defendant Lacy discussed this event with Defendant Butkus. Affidavit of Kathi Lacy at page 29. M. 00737. Despite the decision to decertify Kensington, the fact that Butkus had ordered Babcock to downsize by 50% and this injury, Defendant Butkus made the decision to oppose Edward's discharge from Kensington because "the circumstances were still operatingthat led to the original involuntary admission. We hadn't seen a change in her capacity." M. 1409. He could not remember whether a home study was done before DDSN filed objections to Edward's discharge with the Probate Court. M. 1409. See also 1411. Butkus felt that Edward's mother "couldn't provide the level of care that he needed in the home." M. 1411. This was because "she

was working, she didn't have a lot of resources, income was limited, things of that nature." Id. His assessment was that Edward "couldn't get the care that he needed" at home. M. 1412. He determined that staying at Kensington "was best for him," despite having personal knowledge of the conditions at the facility. M. 1413. Butkus determined "based on our professional assessment" that Mrs. Mims did not have "psychological resources, certainly financial resources" to take care of Edward. "We just didn't think that she would be able to do that." He testified that "it wasn't in his best interest" to be discharged from Kensington. M. 1416. Butkus' decision was that it was in Edward's best interest "To stay in the –remain in the involuntary status and stay where he was." M. 1419 and 1420.

Defendant Lacy actually attended an emergency Probate Court hearing held in Probate Judge Amy McCulloch's chambers on a Sunday afternoon for the purpose of opposing his discharge. Id. at page 31. M. 0759. After the hearing, DDSN"s nurse was sent to the home of Edward's mother and found the "home environment being in good shape" and that "Mrs. Mims appeared to be a very caring and loving mother, that Edward seemed to be getting the kind of care that he needed, and he did not appear to be in any sort of immediate jeopardy." M. 0764 to 0765.

On June, 6, 7 and 8, the court-appointed examiner, Lennie Mullis, attempted to meet with Edward at Kensington to prepare her report for the Probate Court. Upon arriving at Kensington she "noticed a sign stating that the facility has been decertified." Rule 59(e) Motion filed on December 3, 2009 at 115. Affidavit of Lennie Mullis. On June 6, 2005, Mullis was instructed by Babcock Center staff that she must provide her court order to Defendant Johnson. Id. She faxed the order to Johnson on June 7, 2005. But Mullis was again denied entry when she attempted to

examine Edward that evening. Id. On the morning of June 8, 2005, Dr. Johnson left a message with Mullis to call her or Dorothy Goodwin about examining Edward Mims. Goodwin informed Mullis that she would be allowed to examine Edward at 6:00 p.m. on June 8, but when Mullis arrived at 6:15, she again was denied access to Edward. Id.

The court-appointed Visitor, Mary Katherine Bagnal, MSW, CMC, met with Edward and Mrs. Mims and reported to the Probate Court that Mrs. Mims was very attentive to Edward's needs and that he appeared to be familiar and comfortable in his home. Rule 59(e) Motion at 117. On June 9, 2005, an emergency hearing was held in the Probate Court and Mrs. Mims was appointed in a temporary guardianship, with a hearing for the appointment of a permanent guardian scheduled for June 24, 2005. Id. at 107-108. The Order authorized Mrs. Mims to have custody of Edward have the authority to establish his placement. Id. Judge McCulloch ordered DDSN to provide the Court with a service coordinator and a treatment plan. Id.

On June 10, 2005, counsel for DDSN, Jim Hill, wrote to Edward's counsel informing her that DDSN would not allow Edward to visit his mother's home that weekend and that DDSN would "attempt to review this matter next week..." Id. at 122. This letter stated that Babcock Center had appealed the decertification of Kensington and that "Any issue about alternate placement of individuals at this time based on de-certification is premature pending the appeal." Id. Defendant Butkus was copied on this email.

When Mrs. Mims arrived at Kensington to remove Edward from the facility, after providing Defendant Johnson with a copy of the court order, she was not allowed into the facility or to see Edward. M. 2079. She had to call the Columbia Police Department to enforce the Court's order and remove Edward from the facility DHHS had instructed them to depopulate. M.

2079. DDSN counsel, Jim Hill wrote to Edward's court-appointed GAL on June 22, 2005, attempting to obstruct Mrs. Mims' appointment as guardian. M. 2194.

A hearing was held in the Probate Court on June 24, 2005. M. 2189. Defendant Lacy attended and testified at that hearing. M. 2190. On September 28, 2005, DDSN filed a document identified as "Objections" with the Probate Court opposing Mrs. Mims being appointed as Edward's permanent guardian. In this document, DDSN attempted to convince the Court that no guardian should be appointed. M. 2188. If Edward did not have a guardian, there would be no one with authority to sue the Defendants. The Objections state: "More specifically, SCDDSN questions the need for a guardian for Edward, the Petitioner's capacity to function as guardian and suggests that if guardianship is needed, the Court consider the appointment of Edward's sister, Diane Theriot." (Who then worked for Babcock Center.) M. 2193. At that hearing, Defendant Lacy informed the Court that Edward did not qualify for Adult Day Health Care services, in an attempt to force him into a Babcock Center day program. M. 2079.

Attorney Leigh Flynn testified that Babcock Center employees had "intentionally withheld information from me about the conditions at Clusters in 2001 and about the many incidents in which Edward had been injured at the facility so that I would recommend that he be involuntarily committed to the facility." M. 2040. She testified that Babcock Center employees told her that Edward was being abused or neglected at home by Mrs. Mims. Id. She made recommendations for Edward's involuntary commitment "based on this false information which had been provided to me by employees of the Babcock Center and the Department of Disabilities and Special Needs." Id. Attorney Flynn testified that Edward should be released from Babcock Center back into the custody of his mother and that Mrs. Mims' petition to be appointed as

guardian be granted. Id. Ms. Flynn testified that she had represented a number of Babcock Center clients who had been abused and neglected there and that it was not safe to return Edward to the Babcock Center. Id.

Edward's mother was appointed as his guardian at a hearing held in the Richland County Probate Court on September 29, 2005. Rule 59(e) Motion at 130. Judge Belton presided at the hearing. Counsel for DDSN again requested that no guardian be appointed, or, in the alternative, Edward's sister, who worked for Babcock Center until just prior to the hearing, be appointed. Id. Mr. Hill asked the Court to use Edward's funds to pay his sister's attorney fees and that the judge recuse herself. Id. at 131. Edward's sister testified that she had seen Edward once since the spring of 2004, that he had never visited in her home and that she had not visited Edward on holidays for many years. She testified that if appointed as Edward's guardian, she would return him in a facility operated by DDSN. Judge Belton determined that DDSN was not a party to the proceedings and denied DDSN's request to recuse herself. The GAL recommended that Mrs. Mims be appointed as her son's permanent guardian. Id. Mrs. Mims reported that at the hearing, DDSN counsel Hill "sat at counsel table with my daughter, who was an employee of the Babcock Center and who opposed my appointment as guardian for Edward." M. 2079. Mrs. Mims' affidavit states that Edward's Guardian Ad Litem, Ed Kneece asked that Mr. Hill be removed from the court room and he was required to wait in the hallway. M. 2079.

Because Defendants Lacy and Butkus had denied Edward's request to receive Adult Health Care Services from a provider other than Babcock Center, Edward had to file an administrative appeal. The hearing officer reversed the decision of DDSN, finding that Edward was entitled to receive those services. *Mims v. DHHS,* Case No. 05-MISC-034 (MR/RD Waiver -

Adult Day Health Services).

It took Edward's mother four years after his involuntary commitment to secure his release from the Babcock Center. Babcock Center Annual Accountability Report that Stan Butkus presented to the General Assembly for FY 2004-2005 provided a different perspective than that witnessed by Mrs. Mims:

> Dr. Stan Butkus, State Director, was appointed to serve on S.C.'s full Olmstead Committee .... The Olmstead U.S. Supreme Court decision established that individuals living in institutions should be able to move to community options if they desire, that individuals should not be unnecessarily institutionalized, or put at risk of unnecessary institutionalization and that placements move at a reasonable pace.

M. 0266. This Report informs the legislature that "Under his leadership, beginning in 2998 the Department has been on the cutting edge of developing and implementing a state wide service model that relies on consumer choice and consumer satisfaction based on a person-centered organized statewide service delivery system..." M. 0274. According to this Report: "Leadership actively promotes the health, safety and well being of the consumers DDSN serves, as well as the dignity and respect for these individuals and their families." M. 0275.

Media reports told a different story. M. 1911 to 2014. Also, a very different picture from that painted by Defendant Butkus was exposed by the investigation conducted by Protection and Advocacy for Persons with Disabilities, Inc. Their report titled "Unequal Justice for South Carolinians with Disabilites: Abuse and Neglect Investigations" was released on October 27, 2005, one month after Edward was released from captivity. P&A reported "one homicide, two deaths from choking, physical injuries with excruciating pain, and other shocking examples of abuse and neglect." M. 0284. P&A found that DDSN facilities were allowed to investigate

themselves "with little external oversight" and that law enforcement was rarely contacted. This investigation found that "Some of South Carolina's most vulnerable citizens are needlessly suffering, even dying. They will continue to do so..." M. 0285. The Executive Summary begins:

> Physical Abuse. Sexual Abuse. Neglect. Misuse of medications. Few incidents are reported. Fewer are properly investigated. Rarely are offenders held accountable. Those who should protect people with disabilities often fail to do so. The State's response is a fragmented collection of agencies lacking the expertise to properly investigate allegations of abuse, neglect, and exploitation of vulnerable adults. It is a collective failure that needs to become a system.

M. 0287. According to P&A: "The major agency involved with these issues, DDSN, has created policies and procedures that are inadequate in some places and not followed in others...Reporting often is delayed, or in some cases non-existent. Delays in reporting present serious problems with evidence preservation and victim protection." M. 0288 and 0289. Sexual abuse was not investigated and P&A reported that victims were not protected from further harm. Id.

A 2006 audit of DDSN by DHHS reported deficiencies at many Babcock residential facilities "many of which were repeat issues from prior licensing surveys. M. 1302. According to DHHS, in 2003, Babcock Center had double the statewide average of substantiated cases of abuse, neglect and exploitation. M. 1302. By 2004, the rate of substantiated cases of abuse, neglect and exploitation at the Babcock Center had increase to "four times the statewide average." Id. According to this audit:

> The results of the DDSN review of Babcock's residential surveys were provided to Babcock's Executive Director on December 13, 2004. Most of the deficiencies were repeat findings from the 2003 review, and many were found in multiple facilities. A total of 409 residential deficiencies were cited by DDSN licensing..." M. 1303.

These included falsification of medical consents and training date, failure to report a sexual

assault, homes being unsanitary "to the point of being uninhabitable, kitchens and bathrooms being "very dirty" with broken appliances, water damage and rotten cabinets." M. 1303. In 29 out of 33 employees sampled, medical technician training had not occurred. Id.

As a result of these problems, DDSN agreed to reduce Babcock Center's licensed bed capacity by 25%. The closing of Clusters was discussed. M. 1304. Despite these closures, DHHS reported continued "complaints from consumer advocates and families as well as findings of continued problems by various audits and licensing/certification inspections. As a result, DDSN ordered Babcock Center to reduce its capacity by another 25%. Id.

Edward filed a second administrative appeal with DHHS on September 6, 2006, objecting to DDSN's denial of needed services at home. 42 C.F.R. 431.244(a) provides that hearing decisions must be based "exclusively on evidence introduced at a hearing," but the DHHS hearing officer dismissed Edward's appeal without providing a fair hearing, which is required by 42 U.S.C. 1396a(a)(3). The hearing officer held that DHHS had no jurisdiction to hear Edward's complaints for violation of Sections 1396(a)(8) (reasonable promptness), 1396a(a)(23) (free choice), payment of Edward's "band" funding to the Babcock Center, and the failure to enlist sufficient providers. DHHS Order of Dismissal, 06-MISC-044, January 16, 2007. Defendants did not appeal this order. Edward first filed an appeal with the Administrative Law Court, which upheld the dismissal and then with the South Carolina Court of Appeals. Rather than making further futile attempts to obtain an administrative remedy, in consideration of the DHHS hearing officer determined DHHS had no jurisdiction over his claims for violation of the Medicaid Act, Edward opted to file this lawsuit in the Court of Common Pleas in 2007 for violation of these provisions of the Medicaid Act under Section 1983, along with other claims outside of the

jurisdiction of DHHS.

Responding to legislators' concerns, the South Carolina Legislative Audit Council conducted an extensive audit of DDSN programs. M. 0490. This audit that was released in December of 2008 found that the problems identified in prior audits had not been corrected and that the health and safety of clients in DDSN programs was still in jeopardy. After the audit was released, then Senator David Thomas held hearings on the audit findings which were attended by Defendant Kathi Lacy. M. 2017. His office was "flooded with phone calls" from former employees, employees and families who were fearful of retaliation by DDSN, in particular, retaliation by Defendant Lacy. M. 2017. Senator Thomas reported a "pervasive fear of retaliation" against persons who advocate for DDSN consumers. Id.

Since his release from the Babcock Center, Edward has lived safely at home. M. 2079. However, his mother is "always afraid of what Judy Johnson and the officials at Babcock Center will do to me and to Edward to get back at me for getting Edward out of an abusive situation and reporting them to law enforcement and other regulatory agencies." M. 2080.

No questions of material fact exist in Edward's claim for negligence and gross negligence and he is entitled to judgment as a matter of law.

As Madison alleged in *Madison v. Babcock Center*, DDSN and Babcock Center, and the individual defendants have failed to properly supervise facility staff, failed to heed previous warnings and both ignored the requests of his mother that he be released from Babcock Center. *Supra.* Madison's mother testified that she repeatedly complained to DDSN attorney Jim Hill and the director of the Babcock Center about her daughter having inappropriate sexual contacts at the Babcock Center. Id. at 655. Mr. Hill was the attorney representing DDSN in Edward's

involuntary commitment proceedings. M. 2109. He also filed the agency's motion attempting to obstruct his mother from being appointed as Edward's guardian and actively participated in the hearing, although DDSN was found not to be a party. M. 2188 and page 2 of Order appointing permanent guardian. (This Order is contained at M. 2195, but page two is missing in Volume 6, but a complete copy is attached to Plaintiff's Rule 59(e) Motion at page 118.) In *Madison,* the plaintiff, like Edward, was voluntarily placed at the Babcock Center, but DDSN refused to allow her parents to take her out of the facility. Id. at 655.

The complaint alleged that Madison "secretly slipped out of the house sometime after 1 a.m. and left with male Babcock Center consumers. Id. at 654. In her complaint, it was alleged that she had sex and contracted a disease while staying at the Babcock Center home. Id. Reversing the order of summary judgment granted by the circuit court judge, the South Carolina Supreme Court held that "Babcock Center has a duty to exercise reasonable care in supervising and providing care and treatment to clients in its custody." Id. at 656. The Court held that Babcock Center also has a statutory duty to exercise "reasonable care" in supervising clients. Id. at 657. S.C. Code Ann. § 44-20-30(2), (11) and (16) (2002), S.C. Code Ann. 44-20-710 to 1000 (2002), S.C. Code Ann. 44-26-10 to 220 (2002). Having undertaken to render services to Edward for consideration, the Babcock Center had an obligation to protect him so as to prevent him from harming himself or to prevent others from harming him "while staying at the center." Id.

The Court held that, under the common law, that "a private person or business which accepts the responsibility of providing care, treatment or services to a mentally retarded or disabled client has a duty to exercise reasonable care in supervising the client and providing appropriate are and treatment to the client. Id. at 658. The Supreme Court also held in Madison

that DDSN has a "common law duty to exercise reasonable care in supervising the client and providing appropriate care and treatment to the client." Id. DDSN has a common law duty to Edward, whether or not these services are being provided by an independent contractor or the fact that a third party may have committed a criminal act in harming him. Id. at 660. Edward has provided clear and convincing evidence and no question of material fact exists that DDSN, Butkus and Lacy have been negligent in their duty to Edward to adequately supervise the provision of services by the Babcock Center. Id. They have also been negligent by their own conduct, as they had prior notice of inappropriate care being provided to DDSN's clients by the Babcock Center. Id. He has shown through audits, medical records and results of investigations that the risk of harm to Edward was foreseeable and that their neglect was the proximate cause of his injury.

Although gross negligence is normally a "mixed question of law and fact, Edward has proven in this case that the individual and agency defendants were grossly negligent and the evidence he has presented "supports but one reasonable inference." Id. at 661. Proximate cause can be proven by direct or circumstantial evidence. Edward has shown that "but for" the gross neglect of Defendants and their refusal to release him from confinement he would not have been repeatedly injured by dangerous employees and uncontrolled and improperly supervised individuals. M. At 662. Direct evidence in this case includes extensive records documenting his serious injuries. He has also provided extensive circumstantial evidence in the form of investigations, audits and reports by federal, state and advocacy organizations describing truly hellacious conditions he was forced to endure.

Edward has presented extensive evidence that Johnson, Butkus, Lacy, Babcock Center

and DDSN breached their duty of care; that their actions were the proximate cause of his injuries and that the injuries were quite foreseeable. Lacy is responsible for monitoring trends and assuring that federal standards are met in DDSN facilities. She reported Edward's injuries to Butkus, who had sole authority under the involuntary commitment order to move him prior to his mother's appointment as guardian. Not only did audit after audit of Babcock Center's programs document that its residents were at tremendous risk of harm, but Edward's own records show that he was victimized frequently by staff, as well as other clients. Immediate Jeopardy was declared at Kensington on February 28, 2003, less than one year after Edward was moved there from Clusters and the facility was finally sent a notice of termination after Johnson's repeated failures to bring Kensington into compliance. (M. 0046).

Johnson had a long history of failing to protect persons in her care from abuse. A Recommendation to Investigate by the United States Department of Justice reported that when she was in charge of Whitten Center in the mid-1990's it appeared that "residents of Whitten are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights. M. 1065. This document cites federal surveys conducted in 1993 and 1994 that documented the failure to report abuse and neglect. M. 1067. One parent told DOJ investigators that Johnson "talks out of both sides of her mouth" and "tells parents what they want to hear regardless of the truth." M. 1067. In her deposition, Johnson claimed to have seen the DOJ report. M. 913. She was at Whitten Center from 1991 or 1992 until she left South Carolina in 1996. M. 918. The DOJ allegations, which were supported by HCFA (predecessor of CMS) surveys, are strikingly similar to the findings of CMS, DHEC, LAC and P&A under Johnson's reign at Babcock Center.

Johnson, along with other DDSN officials, was sued for failing to protect Scottie Jennings from repeated abuse while at Midlands Center. M. 1131, 1134. Like Edward, he suffered "mysterious injuries" from "cruel and barbaric treatment" and there was no accountability. M. 1136, 1141, 1135, 1180. Jennings claimed that Johnson was grossly negligent by exposing him to "obvious and extreme dangers" and failing to provide reasonable protection due to a conscious lack of concern for his safety. M. 1143. At her deposition, Johnson did not remember much about this lawsuit and she could not remember whether it contained allegations of sexual abuse. M. 925. She came to Babcock Center in 2002 and admitted a number of lawsuits having been settled during her reign. M. 949, 953, 958, 986,987.

Edward has provided evidence showing that he is entitled to judgement as a matter of law on his claims that the Defendants failed to provide proper supervision to protect him from assault, battery and sexual assault; failed to provide supervision to protect him from injury; failed to properly monitor his condition and treatment needs after initiating involuntary commitment proceedings; failed to provide adequate staffing needed to assure his health and welfare; failed to thoroughly investigate reports of abuse, neglect and exploitation; failed to provide services in the least restrictive setting; and failed to report incidents which a reasonable person would suspect to have resulted from abuse or neglect. Such negligence, gross negligence, carelessness, recklessness, and wilful and wanton conduct on the part of the Defendants proximately caused Edward's injuries for which he is entitled to recover actual and punitive damages, attorney fees, expert witness fees, costs and expenses, the amount to be determined by a jury.

For the reasons set forth above, Edward prays for an order granting his Motion for Partial Summary Judgment on his Third Cause of Action for negligence.

Respectfully submitted,

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