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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

S. Jackson Kimball, Special Circuit Court Judge

Case No. 2011-CP-46-4508

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

Appellant

v.

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

Defendants

Of whom

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

Respondent.

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January 7, 2014
Rock Hill, South Carolina

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

FORM 4

JUDGMENT IN A CIVIL CASE

CASE NO. 2011 CP-46-4508

Elizabeth Hope Rainey, as GAL for Owen C. [REDACTED],

The Charlotte-Mecklenburg Hospital Authority

PLAINTIFF(S)

d/b/a Carolinas Medical Center, et al.

DEFENDANT(S)

Submitted by: Monteith P. Todd

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

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☒ See Page 2 for additional information.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j), SCRPC; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

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

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

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

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

INFORMATION FOR THE JUDGMENT INDEX

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

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

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

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

[Signature]
Circuit Court Judge

3063
Judge Code

5/13/13
Date

For Clerk of Court Office Use Only

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

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

[Signature]
ATTORNEY(S) FOR THE DEFENDANT(S)
CLERK OF COURT

Court Reporter:

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

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

· Motion for Summary Judgment on behalf of The Charlotte-Mecklenburg Hospital Authority d/b/a

Carolinas Medical Center, heard on April 18, 2013 in York County, South Carolina.

STATE OF SOUTH CAROLINA)

COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

Elizabeth Hope Rainey, as the
Appointed Guardian ad Litem to
Owen C██████, a minor)

Case No.: 2011-CP-46-4508

Plaintiff,)

v.)

ORDER FOR SUMMARY JUDGMENT

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

Defendants.)

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DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

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

FACTUAL BACKGROUND

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

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

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suspicion that Owen may have been a victim of a non-accidental trauma.

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

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

PLEADINGS AND DISCOVERY

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

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

STANDARD FOR SUMMARY JUDGMENT

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



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

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

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

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

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

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

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

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

DISCUSSION

1. Duty of care.

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

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

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

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

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

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

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

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

A physician, nurse, . . . or any other . . . health professional . . . must report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected as defined in Section 63-7-20.

* * * * *

(D) Reports of child abuse or neglect may be made orally by telephone or otherwise to the county department of social services or to a law enforcement agency in the county where the child resides or is found. (Emphasis added.)

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

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

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

§ 63-7-750. Doctor or hospital may detain child; civil immunity.

(A) A physician or hospital to which a child has been brought for treatment may detain the child for up to twenty-four hours without the consent of the person responsible for the child's welfare if the physician or hospital:

(1) has reason to believe that the child has been abused or neglected;

(2) has made a report to a law enforcement agency and the department pursuant to Section 63-7-310, stating the time the physician notified the agency or department that the child was being detained until a law enforcement officer could arrive to determine whether the officer should take emergency physical

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custody of the child pursuant to Subarticle 3; and

(3) has reason to believe that release of the child to the child's parent, guardian, custodian, or caretaker presents an imminent danger to the child's life, health, or physical safety. A hospital must designate a qualified person or persons within the hospital who shall have sole authority to detain a child on behalf of the hospital.

(B) A physician or hospital that detains a child in good faith as provided in this section is immune from civil or criminal liability for detaining the child. (Emphasis added.)

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

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

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

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

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

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

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

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

2. Immunity regarding reporting of abuse.

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

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



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

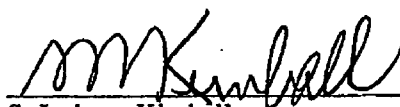
Plaintiff's claim in this case is not premised on the fact that CMHA reported its suspicion of abuse. No issue is raised concerning the fact that Levine reported Owen's condition to DSS, as required by 63-7-310. Rather, Plaintiff's claim is premised on the assertion of a further duty to retain custody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

CONCLUSION

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

AND IT IS SO ORDERED.

May 13, 2013



S. Jackson Kimball
Special Circuit Court Judge
York County

#9

FORM 4

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

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP4604508

Elizabeth Hope Rainey	Owen C [REDACTED]	Charlotte Mecklenburg Hospital Authority Department of Social Services South Carolina York County Sheriffs Department	Carolinas Medical Center Bruce Bryant York County

PLAINTIFF(S)	DEFENDANT(S)
Submitted by:	Attorney for: ☐ Plaintiff ☐ Defendant ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
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☐ Rule 43(k), SCRPC (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j) SCRPC; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

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

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

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

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

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

AND IT IS SO ORDERED.

[Handwritten signature]
B1

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.

Additional Information for the Clerk: _____

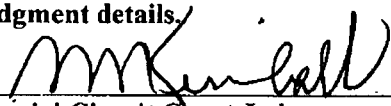
INFORMATION FOR THE JUDGMENT INDEX

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

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

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

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


Special Circuit Court Judge

3063

Judge Code

8/14/2013

Date

For Clerk of Court Office Use Only

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

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

ATTORNEY(S) FOR THE PLAINTIFF(S)

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

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter: Susan Wyatt

David Hamilton - Clerk of Court

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

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

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Elizabeth Hope Rainey, as the appointed
Guardian ad Litem to Owen ~~_____~~, a minor,
Plaintiff(s)

vs.

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

(Please Print)

Submitted By: S. Randall Hood

Address: 1539 Health Care Drive, Rock Hill, SC
29732

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

11-CP - 46-

04508
FILED-RECEIVED
2011 DEC - 1 AM 9:42
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

SC Bar #: 65360

Telephone #: 803-327-7800

Fax #: 803-328-5656

Other:

E-mail: rhood@mcgowanhood.com

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

DOCKETING INFORMATION (Check all that apply)

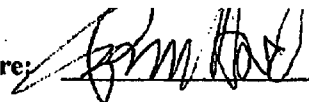
*If Action is Judgment/Settlement do not complete

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

NATURE OF ACTION (Check One Box Below)

☐ Contracts	☐ Torts - Professional Malpractice	☐ Torts - Personal Injury	☐ Real Property
☐ Constructions (100)	☐ Dental Malpractice (200)	☐ Assault/Slander/Libel (300)	☐ Claim & Delivery (400)
☐ Debt Collection (110)	☐ Legal Malpractice (210)	☐ Conversion (310)	☐ Condemnation (410)
☐ Employment (120)	☐ Medical Malpractice (220)	☐ Motor Vehicle Accident (320)	☐ Foreclosure (420)
☐ General (130)	Previous Notice of Intent Case #	☐ Premises Liability (330)	☐ Mechanic's Lien (430)
☐ Breach of Contract (140)	20____-CP-____	☐ Products Liability (340)	☐ Partition (440)
☐ Other (199)	☐ Notice/ File Med Mal (230)	☒ Personal Injury (350)	☐ Possession (450)
	☐ Other (299)	☐ Wrongful Death (360)	☐ Building Code Violation (460)
		☐ Other (399)	☐ Other (499)
☐ Inmate Petitions	☐ Judgments/Settlements	☐ Administrative Law/Relief	☐ Appeals
☐ PCR (500)	☐ Death Settlement (700)	☐ Reinstate Driver's License (800)	☐ Arbitration (900)
☐ Mandamus (520)	☐ Foreign Judgment (710)	☐ Judicial Review (810)	☐ Magistrate-Civil (910)
☐ Habeas Corpus (530)	☐ Magistrate's Judgment (720)	☐ Relief (820)	☐ Magistrate-Criminal (920)
☐ Other (599)	☐ Minor Settlement (730)	☐ Permanent Injunction (830)	☐ Municipal (930)
	☐ Transcript Judgment (740)	☐ Forfeiture-Petition (840)	☐ Probate Court (940)
	☐ Lis Pendens (750)	☐ Forfeiture-Consent Order (850)	☐ SCDOT (950)
	☐ Transfer of Structured Settlement Payment Rights Application (760)	☐ Other (899)	☐ Worker's Comp (960)
	☐ Other (799)		☐ Zoning Board (970)
☐ Special/Complex /Other			☐ Public Service Commission (990)
☐ Environmental (600)	☐ Pharmaceuticals (630)		☐ Employment Security Comm (991)
☐ Automobile Arb. (610)	☐ Unfair Trade Practices (640)		☐ Other (999)
☐ Medical (620)	☐ Out-of State Depositions (650)		
☐ Other (699)	☐ Motion to Quash Subpoena in an Out-of-County Action (660)		
	☐ Sexual Predator (510)		

Submitting Party Signature:



Date:

1/13/12

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

FOR MANDATED ADR COUNTIES ONLY

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

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

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

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

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

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

Elizabeth Hope Rainey, as the)
appointed Guardian Ad Litem to)
Owen C. [REDACTED], a minor,)
Plaintiff)

C.A. Number: 11-CP-46-04508

SUMMONS
(Jury Trial Demanded)

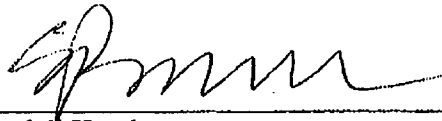
v.)
Charlotte-Mecklenburg Hospital)
Authority d/b/a Carolinas)
Medical Center; South Carolina)
Department of Social Services,)
and Bruce Bryant, as the)
Constitutional Office)
of the Sheriff of York County,)
The York County Sheriff's)
Department, and York County)
Defendants)

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

TO: THE DEFENDANTS IN THE ABOVE NAMED ACTION

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

[SIGNATURE PAGE TO FOLLOW]



S. Randall Hood
Jordan Calloway
Lara Pettis Harrill
MCGOWAN, HOOD, & FELDER, LLC
1539 Health Care Drive
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(803) 327-7800
(803) 328-5656 (Fax)
rhood@mcgowanhood.com
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1169 Ebenezer Road
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(803) 329-4202 (Fax)
shaw@shawlawfirm.net
sheldon@shawlawfirm.net

Rock Hill, South Carolina

November 30, 2011

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

Elizabeth Hope Rainey, as the)
appointed Guardian Ad Litem to)
Owen C. [REDACTED], a minor,)

C.A. Number: 11-CP-46-

04508

Plaintiff)

v.)

COMPLAINT
(Jury Trial Demanded)

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

Defendants)

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

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

PARTIES

Plaintiffs

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

Defendants

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

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

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

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

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

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

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

JOINT AND SEVERAL LIABILITY

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

GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS

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

Kayla Lythgoe and Michael Carduff.

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

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

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

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

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

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

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

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

18. Michael Carduff and Kayla Lythgoe were with Owen Carduff while in Charlotte

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOR A FIRST CAUSE OF ACTION
(Negligence - CMC)

32. Plaintiff realleges and reiterates paragraphs 1 through 31, as though fully set forth herein verbatim, and further alleges:

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

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

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

- a. in failing to adequately consider or determine whether Owen C█████ could be safely discharged into the care of his parents Kayla Lythgoe and Michael Carduff on December 8, 2009;
- b. in failing to adequately recognize or adequately consider the fact that Owen C█████ had been injured by one of his parents and that a social worker from CMC was discharging back to his likely abuser(s);
- c. in failing to implement, or cause to be implemented, adequate additional assessment of the minor Plaintiff's discharge to ensure he was placed back into a safe environment;
- d. in failing to reasonably determine whether Owen C█████'s parents were qualified to assume his care;
- e. in failing to provide or arrange, or reasonably attempting or arrange, another safe and appropriate manner to discharge Owen C█████ to ensure his safety from a likely abuser;
- f. in failing to adequately communicate the condition and safety needs of Owen C█████ to the appropriate staff at the York County Division of SCDSS;
- g. in failing to properly train and educate their employees in the proper manner to discharge a child who the victim of suspected child abuse;
- h. in failing to have proper policies and procedures in place regarding discharge of

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

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

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

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

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

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

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

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

back into the home of the suspected abuser.

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

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

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

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

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

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

minor Plaintiff:

- a. in failing to adequately consider or determine whether Owen C[REDACTED] could be safely discharged into the care of his parents Kayla Lythgoe and Michael Carduff;
- b. in failing to adequately recognize or adequately consider the fact that Owen C[REDACTED] had been injured by one of his parents and that a social worker from CMC was discharging Owen C[REDACTED] back to his likely abuser(s);
- c. in failing to implement, or cause to be implemented, adequate additional assessment of the minor Plaintiff's discharge to ensure he was placed in a safe environment;
- d. in failing to reasonably determine whether or not the parents of Owen C[REDACTED] were qualified to assume the minor Plaintiff's care;
- e. in failing to provide or arrange, or reasonably attempting or arrange, another safe and appropriate manner to discharge Owen C[REDACTED] to ensure his safety from a likely abuser;
- f. in failing to adequately investigate and determine whether it was safe for Owen C[REDACTED] to be in the care and custody of Michael Carduff;
- g. in failing to properly train and educate their employees in the proper manner to ensure a safe placement and discharge of a child who is the suspected victim of child abuse;
- h. in failing to have proper policies and procedures in place in regard to the discharge, placement, investigation, removal and protection of victims of suspected child abuse, especially when the employees or agents are aware of the placement of the child back into the hands of a suspected abuser;
- i. in failing to ensure that the Sheriff or one of his employees had conducted a proper investigation into the injuries of Owen C[REDACTED] and ensured the minor Plaintiff was not at risk of further injury at the hands of one of his parents, and specifically, Michael Carduff;
- j. In negligently per se failing to comply with the children's code in multiple ways, and,
- k. in such other particulars as may be ascertained through discovery procedures undertaken pursuant to The South Carolina Rules of Civil Procedure.

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

FOR A THIRD CAUSE OF ACTION

(Negligence - Sheriff Bryant, York County Sheriff's Department and YC)

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

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

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

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

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

was discharged back into the home of the suspected abuser.

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

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

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

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

- a. in failing to adequately investigate claims of child abuse against Owen C[REDACTED] to consider or determine whether or not Owen C[REDACTED] could be safely protected from his parents Kayla Lythgoe and Michael Carduff;
- b. in failing to adequately investigate and/or recognize or adequately consider the fact that Owen C[REDACTED] had been injured by one of his parents;

- c. in failing to implement, or cause to be implemented, adequate additional investigation of the minor Plaintiff's ability to safely reside in his parent's home or reside in a safe environment;
- d. in failing to reasonably determine whether or not the parents of Owen C█████ were harming Owen C█████;
- e. in failing to take Owen C█████ into protective custody;
- f. in failing to adequately investigate and determine whether it was safe for Owen C█████ to be in the care and custody of Michael Carduff;
- g. in failing to properly train and educate their employees in the proper manner to ensure a safe placement and discharge of a child who is the suspected victim of child abuse;
- h. in failing to have proper policies and procedures in place in regard to the discharge, placement, investigation, removal and protection of victims of suspected child abuse, especially when the employees or agents are aware of the placement of the child back into the hands of a suspected abuser;
- i. In negligently per se failing to comply with the children's code in multiple ways, and,
- j. in such other particulars as may be ascertained through discovery procedures undertaken pursuant to The South Carolina Rules of Civil Procedure.

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

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

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

herein verbatim, and further alleges:

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

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

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

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

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

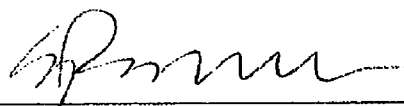
64. The necessities claim in this case is being prosecuted on behalf of the maternal grandparents and the minor plaintiff by the guardian ad litem in this case.

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

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

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

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



S. Randall Hood
Jordan Calloway
Lara Pettis Harrill
MCGOWAN, HOOD, & FELDER, LLC
1539 Health Care Drive
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(803) 327-7800
(803) 328-5656 (Fax)
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1169 Ebenezer Road
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(803) 329-4202 (Fax)
shaw@shawlawfirm.net
sheldon@shawlawfirm.net

Rock Hill, South Carolina

November 30, 2011

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

Elizabeth Hope Rainey, as the)
appointed Guardian Ad Litem to)
Owen C [REDACTED], a minor,)

Plaintiff)

v.)

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

Defendants)

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

C.A. Number: 11-CP-46- 04508

AFFIDAVIT

GEORGE W. SAVARESE, Ph.D., LCSW

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

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

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

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

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

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

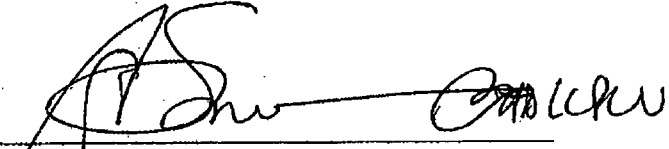
- * In failing to conduct an appropriate and independent psychosocial assessment in order to identify, explore and comprehend the specifics of the risk for child abuse and re-injury related to Owen C [REDACTED]
- * In failing to initiate and facilitate an appropriate discharge plan; and
- * In failing to protect a vulnerable child from further abuse and neglect;

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

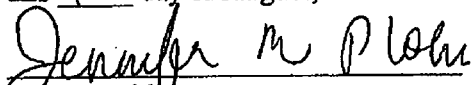
6. The factual basis for my opinion about the breaches of the standard of care by the employees and/or agents of the South Carolina Department of Social Services and Carolinas Medical Center are the medical records of Owen Carduff and the South Carolina (York County) Department of Social Services records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

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

[SIGNATURE PAGE TO FOLLOW]


GEORGE W. SAVARESE, Ph.D., LCSW

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


Notary Public



My Commission expires: 5/26/2012

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

EDUCATION

PH.D.

University of Chicago, School of Social Service Administration, Chicago, Illinois

Concentration: Clinical Social Work/Social Administration/Social Policy Analysis

Dissertation: "Practitioner activity in a family-based approach to treatment of the elderly." A content analysis of an inchoate behavioral treatment model designed to train elderly clients and their families how to modify a wide range of problematic behaviors was conducted in an attempt to offset the need for institutional placement.

June, 1989

M.S.W.

New York University, School of Social Work, New York, New York

Concentration: Clinical Social Work/Social Administration

June, 1980

B.A.

City College of New York, School of Liberal Arts, New York, New York

Concentration: Psychology/Sociology

February, 1978

ADMINISTRATIVE EXPERIENCE

Curaeta Care Systems, Park Ridge & Arlington Heights, Illinois

January, 1995 to present

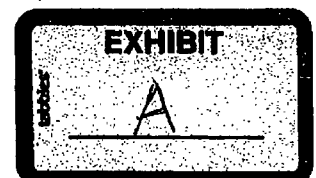
Executive Clinical Director. Founded and direct a private psychosocial services consultation organization which provides psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets; Direct the strategic planning, organizational and program development, research,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

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

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

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

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



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

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

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

ACADEMIC EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRAINING EXPERIENCE

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

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

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

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

CLINICAL EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESEARCH EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER EXPERIENCE

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

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

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

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

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

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

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

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

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

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

VOLUNTARY ACTIVITIES

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

PUBLICATIONS

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

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

MEMBERSHIPS/CERTIFICATIONS/LICENSES

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

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

Elizabeth Hope Rainey, as the)
appointed Guardian ad Litem to)
Owen C. [REDACTED], a minor,)

Civil Action No. 11-CP-46-4508

Plaintiff,)

v.)

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

ANSWER OF DEFENDANT,
CHARLOTTE-MECKLENBURG
HOSPITAL AUTHORITY D/B/A
CAROLINAS MEDICAL CENTER

Defendants.)

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

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

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

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

6. Denied.

7. Denied.

8. Denied.

9. Admitted upon information and belief.

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

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

21. Denied.

22. Admitted.

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

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

25. Denied.

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

30. Denied.

31. Denied.

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

**FOR A FIRST DEFENSE
TO THE FIRST CAUSE OF ACTION**

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

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

34. Denied.

35. Denied.

36. Denied.

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

**FOR A FIRST DEFENSE
TO THE SECOND CAUSE OF ACTION**

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

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

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

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

**FOR A FIRST DEFENSE
TO THE THIRD CAUSE OF ACTION**

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

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

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

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

**FOR A FIRST DEFENSE
TO THE FOURTH CAUSE OF ACTION**

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

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

66. Denied.

67. Denied.

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

**FOR A SECOND DEFENSE
TO ALL CAUSES OF ACTION**

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

**FOR A THIRD DEFENSE
TO ALL CAUSES OF ACTION**

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

**FOR A FOURTH DEFENSE
TO ALL CAUSES OF ACTION**

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

FOR A FIFTH DEFENSE
TO ALL CAUSES OF ACTION

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

FOR A SIXTH DEFENSE
TO ALL CAUSES OF ACTION

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

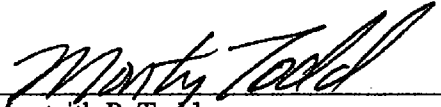
FOR A SEVENTH DEFENSE
TO ALL CAUSES OF ACTION

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

- (a) the judiciary's ability to correct a punitive damage award at the appellate level only upon a finding of passion, prejudice, or caprice is inconsistent with due process guarantees;
- (b) any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;
- (c) the jury's unfettered power to award punitive damages in any amount it chooses is wholly devoid of meaningful standards and is inconsistent with due process guarantees;
- (d) even if it could be argued that a standard governing imposition of punitive damages exists, the standard is void for vagueness; and
- (e) the plaintiff's claim for punitive damages violates the Commerce Clause and Due Process Clause, and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution and Article I, Section 3 of the South Carolina Constitution in that the amount of punitive damages is based upon the wealth and status of the defendant.

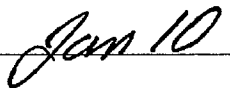
WHEREFORE, having fully answered, this defendant prays that the plaintiff's Complaint be dismissed, with costs, and for such other and further relief as the Court deems just and proper.

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

By: 

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

Columbia, South Carolina

 Jan 10, 2012

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

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

Plaintiff,

v.

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

Defendants.

Civil Action No. 11-CP-46-4508

AMENDED ANSWER OF DEFENDANT,
CHARLOTTE-MECKLENBURG
HOSPITAL AUTHORITY D/B/A
CAROLINAS MEDICAL CENTER

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

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

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

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

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

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

20. Denied.

21. Denied.

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

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

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

25. Denied.

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

27. Admitted, upon information and belief.

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

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

30. Denied.

31. Denied.

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

FOR A FIRST DEFENSE
TO THE FIRST CAUSE OF ACTION

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

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

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

34. Denied.

35. Denied.

36. Denied.

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

**FOR A FIRST DEFENSE
TO THE SECOND CAUSE OF ACTION**

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

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

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

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

**FOR A FIRST DEFENSE
TO THE THIRD CAUSE OF ACTION**

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

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

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

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

FOR A FIRST DEFENSE
TO THE FOURTH CAUSE OF ACTION

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

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

66. Denied.

67. Denied.

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

FOR A SEVENTH DEFENSE
TO ALL CAUSES OF ACTION

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

- (a) the judiciary's ability to correct a punitive damage award at the appellate level only upon a finding of passion, prejudice, or caprice is inconsistent with due process guarantees;
- (b) any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;
- (c) the jury's unfettered power to award punitive damages in any amount it chooses is wholly devoid of meaningful standards and is inconsistent with due process guarantees;
- (d) even if it could be argued that a standard governing imposition of punitive damages exists, the standard is void for vagueness; and
- (e) the plaintiff's claim for punitive damages violates the Commerce Clause and Due Process Clause, and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution and Article I, Section 3, of the South Carolina Constitution in that the amount of punitive damages is based upon the wealth and status of the defendant.

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

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

By: _____

Monteith P. Todd

1310 Gadsden Street

Post Office Box 11449

Columbia, South Carolina 29211

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

February 1, 2012

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

Elizabeth Hope Rainey, as the)
appointment Guardian ad Litem)
to Owen C. [REDACTED] a minor,)
Plaintiff,)

vs.)

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

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

Civil Action No.: 2011-CP-46-04508

**ANSWER OF THE DEFENDANT
SOUTH CAROLINA DEPARTMENT OF
SOCIAL SERVICES**

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

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

FOR A FIRST DEFENSE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

working with the family, and stated that, as of December 7, 2009, the hospital could not determine if the child's injuries were accidental or non-accidental, that while the hospital could not rule out trauma, the family had no clear history of trauma, and the hospital's concerns were mostly for lack of supervision. This Defendant further affirmatively alleges that, upon inquiring of the doctor who was working with the child, this Defendant's supervisor was told that the doctor could not determine whether the injuries were accidental or not at that point. The remaining allegations of paragraphs 23 and 25 are denied.

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

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

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

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

FOR A SECOND DEFENSE

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

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

FOR A THIRD DEFENSE

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

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

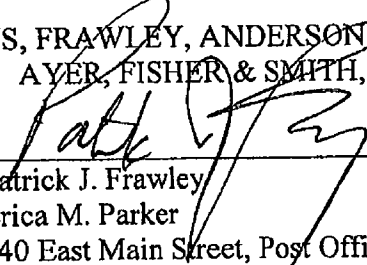
FOR A FOURTH DEFENSE

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

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

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

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

By: 

Patrick J. Frawley
Erica M. Parker
140 East Main Street, Post Office Box 489
Lexington, South Carolina 29072
Phone No.: (803) 359-2512

ATTORNEYS FOR THE DEFENDANT
SOUTH CAROLINA DEPARTMENT OF
SOCIAL SERVICES

Lexington, South Carolina
January 9 2012

STATE OF SOUTH CAROLINA)

IN THE FAMILY COURT)

COUNTY OF YORK)

CASE NO.: 2011-CP-46-4508

ELIZABETH HOPE RAINEY, as the)
appointed Guardian ad Litem)
to Owen C [REDACTED], a minor,)

PLAINTIFF,)

-vs-)

TRANSCRIPT OF RECORD

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

DEFENDANTS.)

April 18, 2013
Rock Hill, South Carolina

B E F O R E:

Honorable S. Jackson Kimball, III, Judge.

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

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

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

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

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

Shannon McGilberry, Court Reporter

COPY

1 THE COURT: All right. This is case number 2011-CP-46-
2 4508, Elizabeth Hope Rainey, by Guardian ad Litem -- as
3 Guardian ad Litem, I mean, against Charlotte-Mecklenburg
4 Hospital Authority and others. Present, representing the
5 plaintiffs, Mr. Randy Hood.

6 Are you Mr. Todd?

7 MR. TODD: I am Mr. Todd, Your Honor.

8 THE COURT: Mr. Monteith P. Todd. This is the
9 defendant's -- Charlotte-Mecklenburg Hospital Authority's
10 motion for summary judgment. Mr. Todd, if you're ready, go
11 ahead.

12 MR. TODD: Yes, sir, Your Honor. Thank you. Your
13 Honor, I filed this motion on behalf of Charlotte-
14 Mecklenburg Hospital on two grounds, one, that the
15 plaintiffs cannot show any duty that was breached and, two,
16 on immunity.

17 The facts of the case are, and I would think that there
18 won't be any -- we stipulate to these certain facts, that
19 Owen C. [REDACTED] was a three-month-old child in December of
20 2009. There was some event at home and his parents took him
21 to Piedmont Medical Center. From Piedmont Medical Center,
22 he was transferred to Charlotte-Mecklenburg Hospital,
23 Levine's Children's Hospital. After initial workup, a CT
24 scan revealed that he had a subdural hematoma.

25 THE COURT: Right.

1 MR. TODD: There was no good explanation from the
2 parents as to how that got there. That subdural hematoma
3 led Charlotte-Mecklenburg Hospital -- raised a suspicion of
4 non-accidental trauma, child abuse.

5 Charlotte-Mecklenburg Hospital called the South
6 Carolina DSS, the York County DSS, and reported its
7 suspicion of a non-accidental trauma. DSS began its
8 investigation. It was a Sunday night when the call was
9 made. The investigation was started that Sunday night.

10 DSS continued its investigation. Charlotte-Mecklenburg
11 Hospital, the doctors there, continued to do a workup and
12 there were additional studies, additional evaluations,
13 which, for all intents and purposes, were normal.

14 At the end of the medical workup, the attending
15 physician --

16 THE COURT: As I understood it, they couldn't -- they
17 didn't find anything -- anything to cause the subdural
18 hematoma; right?

19 MR. TODD: No, sir.

20 THE COURT: No bruises, no scratches, nothing?

21 MR. TODD: They was no -- they were not determined --
22 the cause was not determined and at the end of it when they
23 done the --

24 THE COURT: And the result of the neurological exam was
25 within normal limits; right?

1 MR. TODD: Yes, sir.

2 THE COURT: All right.

3 MR. TODD: And at the end of -- when the tests had been
4 done, they'd done these additional tests, the full-body scan
5 and ophthalmological exam, the result was that the doctors
6 could not say that it was child abuse.

7 THE COURT: What did the body scan and the
8 ophthalmological exam reveal, if anything? I didn't see
9 that.

10 MR. TODD: Yes, sir. It -- the body scan was normal.
11 There were no other -- no indication of any breaks or
12 bruises. The ophthalmological scan -- I'm having a hard
13 time saying it. When the court reporter types it out,
14 hopefully, she'll help me out there.

15 THE COURT: Shannon's not saying it, either.

16 MR. TODD: What they're looking for is retinal
17 hemorrhages, because retinal hemorrhages can be a sign of
18 shaken baby.

19 THE COURT: Right.

20 MR. TODD: There were no retinal hemorrhages.

21 THE COURT: Okay.

22 MR. TODD: So at the end of the day, the doctors
23 couldn't say -- they said we cannot rule out accidental
24 trauma or we can't rule out non-accidental trauma. We can't
25 make a definitive statement either way.

1 THE COURT: Well, let me ask you this based on what Mr.
2 Hood sent me. What is the status of a patient, a child, who
3 comes to CMC -- well, let me back up. How did Piedmont
4 refer the child to CMC?

5 MR. TODD: Well, Piedmont did -- well, they referred
6 him by ambulance. That's really what you --

7 THE COURT: That's how they transported him; no?

8 MR. TODD: What happened is Piedmont -- the child -- if
9 you look at the records from Piedmont,---

10 THE COURT: Right.

11 MR. TODD: ---the child was doing well at Piedmont.
12 There was, essentially, a pretty normal exam at Piedmont.
13 They did a spinal tap at Piedmont and the spinal tap
14 revealed blood in the spinal fluid---

15 THE COURT: All right.

16 MR. TODD: ---and that was what led to the transfer to
17 Charlotte-Mecklenburg Hospital.

18 THE COURT: And why?

19 MR. TODD: I guess --

20 THE COURT: Well, why, but why does blood in the spinal
21 fluid -- I mean, if you or I showed up at Piedmont with
22 blood in the spinal fluid, would they refer us to CMC?

23 MR. TODD: Your Honor, we've not deposed the doctors at
24 Piedmont Medical Center based on what I --

25 THE COURT: In other words, was the referral for an

1 evaluation for abuse -- I'll just ask it straight up. Was
2 it a referral for an evaluation for abuse or a referral for
3 a medical reason only?

4 MR. TODD: For a medical reason.

5 THE COURT: All right.

6 MR. TODD: And I'm getting ahead of myself, but there's
7 certain -- if there's a suspicion of child abuse, then
8 certain persons are required to report. There's a reporting
9 statute---

10 THE COURT: Right.

11 MR. TODD: ---that sets it forth.

12 THE COURT: Right.

13 MR. TODD: If Piedmont had suspected child abuse, then
14 they would have had the obligation to report.

15 THE COURT: All right.

16 MR. TODD: So I think what the answer to your question
17 is there was no suspicion by Piedmont, because Piedmont made
18 no report.

19 THE COURT: All right.

20 MR. TODD: Now, there was some testimony from the
21 mother about police officers being there at Piedmont, but we
22 really don't know that. We do know that there was no report
23 from Piedmont to DSS.

24 THE COURT: As required by statute.

25 MR. TODD: As required by statute.

1 THE COURT: All right. Go ahead.

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

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

9 MR. TODD: It was given by --

10 THE COURT: Or direction given.

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

14 THE COURT: Okay.

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

20 THE COURT: Serious --

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

23 THE COURT: All right.

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

1 THE COURT: So DSS, in connection with this incident,
2 didn't seek any kind of Court Order removing the child
3 temporarily while there was an investigation?

4 MR. TODD: No, sir.

5 THE COURT: All right.

6 MR. TODD: Getting back to our argument in this case,
7 it relates to a question of duty and a question of immunity.

8 Basically, what the plaintiff's argument is, what their
9 theory is, the crux of their case is that Carolinas Medical
10 -- Levine's Children's Hospital, Carolinas Medical Center,
11 should have taken some action that would have caused DSS or
12 would have led to this child being removed from the custody
13 of his parents.

14 THE COURT: Or not -- well, as I read it, the hospital
15 shouldn't have released the child to his parents. Is that
16 right, Mr. Hood?

17 MR. HOOD: Yes, Your Honor. That's part of what we're
18 saying.

19 MR. TODD: Right. Well, that gets to the duty
20 question.

21 THE COURT: Well, sure.

22 MR. TODD: This child was ready for discharge---

23 THE COURT: Sure.

24 MR. TODD: ---medically. The child was medically
25 stable and under South Carolina statutes, there is a

1 Children's Code, which is set forth at 63-7-10, ed. sec., it
2 sets forth what the duties and the obligation are of
3 individuals -- of entities when there's a suspicion of child
4 abuse and the first obligation is if you suspect it is to
5 report and in that case there's no question that this was
6 done.

7 Now, there is a -- it's an interesting and it's not
8 really applicable to this case, but there is a Supreme Court
9 -- a South Carolina Supreme Court case where they say the
10 obligation -- or the failure to report does not lead to a
11 civil cause of action. That's Doe versus Marion and it's
12 set forth in my brief.

13 But anyway, in this case, a report was made and so the
14 hospital complied with its obligations to report and they
15 provided the information about the medicine, the medical
16 condition and their opinions to DSS, but what the hospital
17 cannot do is they cannot remove a child from the custody of
18 his parents.

19 They cannot -- you know, and the failure -- I mean, I
20 don't know what the plaintiff's argument is, maybe they
21 should have kept the child in the hospital forever. I mean,
22 I guess if you take their argument to the extreme, that's
23 what it is, but that would be false imprisonment or
24 kidnapping. The child was ready for discharge. DSS advised
25 the hospital to discharge the child to his parents and so

1 their obligation --

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

3 MR. TODD: There's no dispute about that. It's in the
4 testimony of DSS and we've got these depositions we can, you
5 know, can hand up, but there's no dispute that DSS advised
6 them to discharge the child to his parents and that was
7 done.

8 The plaintiff's argument is that somehow there should
9 have been some additional investigation and additional
10 information presented to DSS, but still, the obligation --
11 the decision about the family relationship, the decision to
12 remove the child from his parents, that's not for a private
13 entity. That is something that's a state entity and this
14 children's code sets it out and it says -- it sets forth the
15 statutes, if it's law enforcement, if it's DSS, exactly how
16 that is to be accomplished and, ultimately, it would be a
17 decision for the Family Court, unless the parents consented
18 to the removal of the child.

19 THE COURT: Okay.

20 MR. TODD: But anyway, the report was made and DSS, as
21 it was their obligation to do, it was their duty to do, made
22 the decision and gave the instruction. So the plaintiff
23 makes the argument about duty, as near as I can tell it, on
24 two things: on expert testimony and on internal procedures.

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

1 one for the Court. You cannot create a duty through expert
2 testimony.

3 The first case on that was Trotter versus State Farm,
4 which is a 1987 case. It was actually my case. It's a
5 Court of Appeals case, where -- it had to do with an
6 insurance agent and the insurance agent's duty to give
7 advice concerning an insurance policy and in that case the
8 plaintiff had multiple experts, but the Court of Appeals
9 said you cannot create a duty by expert testimony. It is a
10 question for the Court.

11 THE COURT: Question of law.

12 MR. TODD: Question of law for the Court. Same thing
13 in two other cases cited. They seek to create a duty
14 through internal procedures. Howe versus State Farm; that's
15 another one of my cases. You cannot create a duty through
16 internal policies and procedures, just as you cannot create
17 a duty through expert testimony, through advertisements,
18 through anything. It is a question for the Court, a
19 question of law, and the duties are set forth in the
20 children's code. A private individual, a private hospital,
21 cannot make -- cannot remove a child from his parents.

22 Now, they do, under that statute, have -- in North
23 Carolina they have allowed for a twelve-hour emergency
24 custody.

25 THE COURT: Well, he's relying on South Carolina law.

1 MR. TODD: In South Carolina it's twenty-four hours,
2 but you can hold the child until law enforcement comes in
3 and makes a decision.

4 THE COURT: Wasn't this child -- this child was in the
5 hospital for a day so?

6 MR. TODD: The child was in the hospital for --

7 THE COURT: I thought I got that -- I figured that out.
8 It was more than --

9 MR. HOOD: It was the 5th through the 8th.

10 THE COURT: Huh?

11 MR. HOOD: Fifth through the 8th.

12 THE COURT: Yeah. Okay. I thought -- it was multiple
13 days, so that doesn't matter anyway.

14 MR. TODD: It was December the 5th until December the
15 9th.

16 THE COURT: The child was in the hospital over a period
17 of time before they released him to his parents?

18 MR. TODD: Yes, sir.

19 THE COURT: Okay.

20 MR. TODD: And, you know, it was a month or so before
21 the child was brought back. So anyway, the question of
22 duty, but it set forth you cannot create a duty through
23 expert testimony, through internal policies and procedures.
24 That's set forth in the cases we've cited.

25 THE COURT: But what does -- and I don't know if it

1 matters. Upon what basis or -- I don't want to call it a
2 pretext, but upon what basis did CMC keep the child for the
3 number of days that -- just running tests all that time?

4 MR. TODD: They were doing the workup to make sure --
5 you know, the child came in with the subdural hematoma.

6 THE COURT: There's no -- no treatment administered
7 during that time?

8 MR. TODD: Really minimal treatment. It was mostly an
9 evaluation and a workup.

10 THE COURT: All right. Go ahead.

11 MR. TODD: Okay. I think I've addressed the duty.
12 It's a question of the Court and in this case there's no
13 duty.

14 Now, the other ground is immunity, which is set forth
15 clearly --

16 THE COURT: Why doesn't -- and I'm forgetting the
17 phraseology now, but why doesn't the -- or how does the law
18 that surrounds a non-delegable duty, like in the hospital
19 cases where somebody that doesn't work for the hospital
20 commits the tort, but the hospital is nevertheless
21 responsible? I know there was a -- actually, that case had
22 to do with an architect, didn't it?

23 MR. TODD: Well, there's a -- I'm not sure what case
24 you're talking about. It may be --

25 THE COURT: It was Baptist Hospital, I think, in

1 Columbia. I can't -- I'm bad about the names of cases, but
2 the point was that the contractor, I believe, had a non-
3 delegable duty. Anyway, address that, 'cause he claims
4 that, a non-delegable duty.

5 MR. TODD: Your Honor, I've got to confess. I'll have
6 to read that case.

7 MR. HOOD: Your Honor, what we're saying is that the
8 hospital has a duty and we've listed the cases, including
9 non-delegable duty. You can't delegate --

10 THE COURT: Okay. I'll hear --

11 MR. HOOD: Yes, Your Honor.

12 MR. TODD: Well, in this case it's not -- the decision
13 about removal of the child, the decision of what to do with
14 the child and his parents is with DSS. The State and the
15 legislature has clearly said that is where the duty lies.
16 It is not a duty which is imposed on the hospital, CMC to
17 begin with, so there's no duty. It's not a question where
18 -- you know, it's not a question of non-delegable duty,
19 'cause there's no duty to begin with.

20 THE COURT: Well, I think that's the argument they made
21 in the non-delegable duty cases. The other person had a
22 duty, but we didn't.

23 MR. TODD: Well, in the case -- you know, the case I'm
24 familiar with, the Tumi case, there was an apparent agency
25 argument there, but I really would have to read the Baptist

1 case you're referring to.

2 THE COURT: I think it was Baptist. Go ahead. I'm
3 sorry.

4 MR. TODD: I'm vaguely familiar with the case, but I've
5 not read the decision to be able to address it with you. I
6 understand there was a contractor or vendor who was
7 unloading --

8 THE COURT: A vendor.

9 MR. TODD: -- who was unloading something on -- for
10 Baptist. Baptist had said this is where you do the
11 unloading and so -- but I just don't know enough about the
12 case to address it.

13 THE COURT: That's fine.

14 MR. TODD: And I'll be happy to go home, go back to my
15 office, read the case and --

16 THE COURT: No. Mr. Hood can tell me about it.

17 MR. TODD: Okay. The other thing is in section 63-390
18 there's immunity the legislature clearly sets forth.

19 THE COURT: Yeah; 390. Right.

20 MR. TODD: It says, a person required or permitted to
21 report, pursuant to section 63-7-310, or who participates in
22 an investigation or judicial proceeding resulting from the
23 report, acting in good faith, is immune from civil and
24 criminal liability.

25 Now, what -- in their brief they don't address the

1 phrase who participates in the investigation and the theory
2 in this case is that CMC, by providing information to DSS,
3 is liable because they didn't provide enough information for
4 DSS to make the decision to remove the child from the home,
5 but this statute, the clear wording of the statute, provides
6 the hospital immunity.

7 THE COURT: Okay. Mr. Hood.

8 MR. HOOD: Your Honor, as opposed to going through all
9 the stuff that I put in my brief, I'm going to address the
10 arguments of Mr. Todd, because I think it would be much more
11 succinct.

12 Here's the case, Your Honor, I would like for you to
13 look at and this is a case -- we looked everywhere for
14 something that would have some applicability and this is the
15 closest thing we could find in the state of South Carolina
16 and this is where there was a mentally --

17 THE COURT: Let me sure about -- before you start in,
18 is there any distinction you want to make about the facts
19 that he recited?

20 MR. HOOD: Just the fact that this child was sent from
21 Piedmont Medical Center and whether Piedmont Medical Center
22 sent him up there for abuse or for further treatment, that's
23 not been said anywhere. Piedmont could have decided not to
24 make a call or they could have negligently failed to make a
25 call, but it doesn't mean that --

1 THE COURT: Well, what do you know about why the child
2 was sent from Piedmont?

3 MR. HOOD: We just know that he was sent because there
4 was a bloody tap,---

5 THE COURT: Okay.

6 MR. HOOD: ---which would indicate either one of two
7 things. There's probably either some cerebral vascular
8 accident or there may be some type of meningitis.

9 THE COURT: Sure.

10 MR. HOOD: And so it's one of those two things. If
11 they suspected cerebral vascular accident, --

12 THE COURT: So they sent him to Levine because it's a
13 specialty place?

14 MR. HOOD: It's a specialty place, but also, you know,
15 if it's a -- if he's got a brain bleed, better to get him up
16 there with a pediatric neurosurgeon---

17 THE COURT: Right.

18 MR. HOOD: ---who can address that. Now, whether --
19 now, in the policies of Levine Children's Hospital -- and we
20 haven't gotten the policies from Piedmont since we haven't
21 made any allegations against them -- it says any child
22 between the ages of zero and six months who presents with an
23 injury, it is a suspicion of abuse is confirmed. That's it.

24 THE COURT: Say that again.

25 MR. HOOD: Yes, Your Honor.

1 THE COURT: I didn't read these --

2 MR. HOOD: Let me read it from their own --

3 THE COURT: -- all the pages you gave me. I read part
4 of them.

5 MR. HOOD: Let me right from the pages, Your Honor.

6 THE COURT: Which page are you on? Are you in your
7 notebook?

8 MR. HOOD: Yes, Your Honor. I'm under B-3.

9 THE COURT: B-3; yes, sir.

10 MR. HOOD: Excuse me. Not confirmed, suspicious for
11 child abuse.

12 THE COURT: B-3 what?

13 MR. HOOD: Roman numeral I, Your Honor.

14 THE COURT: Roman numeral I.

15 MR. HOOD: It says child physical abuse.

16 THE COURT: Hold on one second. Exhibit -- I'm in
17 Exhibit 3; right? I don't see Roman numeral I.

18 MR. HOOD: I'm sorry, Your Honor. It's under 3 and
19 page -- I'm sorry, Your Honor. I gave you the wrong page.
20 On the bottom, Your Honor, it's 7 of 23. It says 7 of 23.

21 THE COURT: Okay. All right. Go ahead.

22 MR. HOOD: Yes, Your Honor. Under Roman numeral I it
23 says, injury, bruises, burns, fractures, this list is not
24 inclusive, it should be considered suspicious for physical
25 abuse.

1 THE COURT: Let me just read that. I didn't read this
2 yesterday. Okay.

3 MR. HOOD: Yes, Your Honor.

4 THE COURT: Okay. Go ahead.

5 MR. HOOD: And so if Piedmont had a similar type thing,
6 they would have had a duty and obligation to --

7 THE COURT: Well, I'm not worried about Piedmont.

8 MR. HOOD: Oh, I know, but you had asked about was
9 there something about the facts---

10 THE COURT: Yeah, I know.

11 MR. HOOD: ---and that was the one thing I said was
12 whether Piedmont or not -- but getting down to the duty of
13 -- as far as the facts that I think that one thing that was
14 not said -- a couple of things, honestly, Your Honor. This
15 child was put up there on the 5th. There were not just one
16 subdural hematoma, there were two.

17 THE COURT: All right. Let me stop you. Under that
18 Roman numeral, as I read this, it's a protocol beginning
19 with the identification of an injury,---

20 MR. HOOD: Yes, Your Honor.

21 THE COURT: ---leading to obtaining a certain course of
22 history, which leads to and ends with an evaluation
23 protocol; right?

24 MR. HOOD: Yes.

25 THE COURT: Or evaluation and treatment.

1 MR. HOOD: Yes, and then it goes to other things and
2 there are evaluation and treatment for different things and
3 it goes through page 23, which is the algorithm of what you
4 do in regard to if there's a suspicion of abuse going all
5 the way through --

6 THE COURT: All right. Where does -- what is the
7 predicate of Roman numeral I? That is, beyond treatment,
8 what, if anything, does it lead to? What is required?

9 MR. HOOD: It requires a -- when there's a suspicion of
10 child abuse, it requires a reporting to DSS.

11 THE COURT: Okay. All right. What else?

12 MR. HOOD: It requires, when you report to DSS, it also
13 requires that you do a -- complete the McCullough scan form.

14 THE COURT: Well, we've done that. That would be under
15 C.

16 MR. HOOD: Yes. This is a whole protocol, Your Honor.
17 I just gave you the whole protocol.

18 THE COURT: I understand that. What I'm saying is it
19 stops after the treatment.

20 MR. HOOD: It continues -- this is the way it was
21 presented to us from Carolinas Medical Center.

22 THE COURT: Okay. Here we go. C-1 says, refer to CHS
23 policy PR110.03 for policies regarding reporting of
24 juveniles suspected of being abused or neglected. Where is
25 that? Have you got that in here?

1 MR. HOOD: Okay. Hold one second, Your Honor. I'm
2 looking at some of the other experts. Your Honor, I don't
3 know that I've got that in the stuff that I have submitted,
4 because they did actually make the report and there wasn't
5 --

6 THE COURT: Yeah.

7 MR. HOOD: Wait a minute. Here it is, Your Honor.

8 THE COURT: Okay. Where are you?

9 MR. HOOD: Under -- it's page 21 of 23.

10 THE COURT: All right.

11 MR. HOOD: This is the certification of necessity for
12 retention of custody.

13 THE COURT: That's under North -- the thing -- that
14 North Carolina statute.

15 MR. HOOD: No, Your Honor. This is 21 of 23. This is
16 -- it's PR110 --

17 THE COURT: What I'm saying is this necessity for
18 retention of custody refers, essentially, back to this North
19 Carolina general statute that you've got. What is it?
20 78308. It looks like an 8.

21 MR. HOOD: Let me make sure you're looking at what I'm
22 looking at, Your Honor.

23 THE COURT: Nineteen of 23.

24 MR. HOOD: It would be the next --

25 THE COURT: That's actually an Order.

1 MR. HOOD: I think it's the next -- this attachment B,
2 Your Honor.

3 THE COURT: I've got that.

4 MR. HOOD: Yes, Your Honor. I'm sorry.

5 THE COURT: What I'm trying to say is that -- turns out
6 that is a form that seems to me to try to fit into a North
7 Carolina statute that permits retention of custody that Mr.
8 Todd referred to.

9 MR. HOOD: Right.

10 THE COURT: Okay. All right. Go ahead.

11 MR. HOOD: Okay. Your Honor, addressing the duty issue
12 from Mr. Todd,---

13 THE COURT: Yes.

14 MR. HOOD: ---that he had talked about,---

15 THE COURT: Yes.

16 MR. HOOD: ---we've looked and we -- and I've handed up
17 the case, Your Honor, Madison versus Babcock Center. This
18 is the closest thing that we could find to this situation.

19 This case involved a vulnerable adult, who is mentally
20 retarded, and she was put into a private center and it was
21 working with some state agencies, the South Carolina
22 Department of Disabilities and Special Needs, SCDDSN as
23 opposed to DSS, and in that particular case there were
24 absolute duties that were owed by statute, but the South
25 Carolina Supreme Court said, not only that, they said that

1 the Department, and they're talking about DSS here, but it
2 gets into Babcock Center as well, that the center owed a
3 common law duty of care to be necessary to prevent her from
4 harming herself or prevent others from harming her while
5 staying at center and Department had a common law duty to
6 exercise reasonable care and supervising and providing
7 appropriate care and treatment for residents.

8 THE COURT: Let me stop you. That was one of the
9 questions I had yesterday. This -- and I didn't know it was
10 this case. This case involves resident care; right?

11 MR. HOOD: That is correct, Your Honor.

12 THE COURT: And a common-law duty arising just by
13 virtue of the fact that it had, essentially, custody, care
14 and control---

15 MR. HOOD: And it assumed care and custody.

16 THE COURT: ---of the disabled person, mentally-
17 disabled person?

18 MR. HOOD: Right.

19 THE COURT: All right. Go ahead.

20 MR. HOOD: And whether it's mentally disabled, but
21 disabled, as we all know, under statutes in South Carolina,
22 is a disability could be anything from somebody who is
23 mentally retarded or a child who's under the age of
24 eighteen.

25 THE COURT: I agree.

1 MR. HOOD: So you're talking about a common-law duty
2 and Mr. Todd --

3 THE COURT: But doesn't that duty arise out of the fact
4 that this agency had care, custody and control of the
5 person, of this disabled person, as a matter of fact?

6 MR. HOOD: They had care and custody of that particular
7 person, but it -- the way I read this, it said she was --
8 that Babcock Center, and I'm reading directly from the page
9 -- Babcock Center had a special relationship with appellant,
10 because she was a client with special needs and
11 disabilities, admitted for care and treatment at the center.

12 THE COURT: Correct.

13 MR. HOOD: Admitted. Which in this case, our child, he
14 was admitted for care at Carolinas Medical Center and so in
15 this situation --

16 THE COURT: Is there any contention that -- that raises
17 my next question -- the next question I had. Is there any
18 question that that injury to the child occurred -- and I
19 think the answer's obvious. There is no question that
20 injury to the child did not occur while the child was within
21 the care and control of the hospital?

22 MR. HOOD: No, Your Honor, and in fact, I think that
23 brings up even a greater issue. They, actually, were so
24 concerned that there was something going on with these
25 parents, they had a sitter for twenty-four hours a day---

1 THE COURT: Okay.

2 MR. HOOD: ---sit in that room.

3 THE COURT: While the child was a patient?

4 MR. HOOD: While the child was a patient.

5 THE COURT: Okay.

6 MR. HOOD: And that sitter -- to me, they didn't have a
7 duty to do that. They took on that duty to provide that
8 type of care---

9 THE COURT: Correct.

10 MR. HOOD: ---and they assumed that duty.

11 THE COURT: While the child was in their care or
12 custody.

13 MR. HOOD: While that child was in their care or
14 custody, just as they did when they had social work come in
15 and their own algorithm says that you can have a medical
16 discharge, but the difference in this case is just because
17 you're medically discharged doesn't mean that you're
18 socially discharged.

19 The neurosurgeon in this case, Dr. Scott McClanahan,
20 said the child is okay for medical discharge, but it must be
21 discussed with the social worker. So --

22 THE COURT: What is a -- is there a protocol, a
23 separate protocol of the hospital that sort of explains or
24 -- you called it an algorithm -- an algorithm for social
25 discharge?

1 MR. HOOD: The algorithm says when medically clear --

2 THE COURT: Why do we call it an algorithm?

3 MR. HOOD: Because it's --

4 THE COURT: That's got nothing to do with the case.

5 MR. HOOD: It's an attachment F and it's part of that
6 whole thing --

7 THE COURT: I would call it a protocol.

8 MR. HOOD: A protocol. I call it a rule, a safety
9 rule.

10 THE COURT: Where is it?

11 MR. HOOD: It's on page 23 of 23, Your Honor,---

12 THE COURT: Twenty-three of 23.

13 MR. HOOD: ---up under that B-3.

14 THE COURT: All right, sir. Hang on. Okay.

15 MR. HOOD: And it says, when medically cleared, --

16 THE COURT: Okay. Hang on a minute. Oh, they call it
17 an algorithm. Okay. Sorry. Okay. The end of that
18 algorithm is, when medically cleared, do not discharge child
19 until disposition has been determined by medical social
20 worker and DSS.

21 MR. HOOD: And DSS. Not and/or DSS, it's and DSS.

22 THE COURT: I understand.

23 MR. HOOD: And so in this particular situation, our
24 experts that we have, Your Honor, we're not trying to -- the
25 duty of law is yours. That's yours to determine. That's a

1 duty of law.

2 We have -- this notebook that I have given to Your
3 Honor discusses what the -- we're not creating those things.
4 He's elucidating us or -- on as far as what the policies
5 are, the standards in the industry and that kind of thing,
6 but in this particular case -- and Mr. Todd, I'm going to
7 use his brief and in his brief, he himself said that -- and
8 he states -- and he's quoting from that Madison case, a
9 legal duty can be created by statute, and he talked about
10 that, a contractual relationship. This child was up there
11 receiving medical care for which he was billed, status,
12 property interest or some other special circumstance.

13 Everybody understands that if you're under -- if you're
14 admitted for care to a hospital, that they have different
15 things. If you're admitted to a heart unit, you may have
16 cardiology standards of care that would apply.

17 In this case, we have social worker standards of care
18 that apply.

19 THE COURT: Here's what troubles me about this and it's
20 a conflict it seems to me. Other -- well, let's say it this
21 way: the hospital apparently, from what I have reviewed --
22 if there's something here I haven't reviewed, tell me -- I
23 know of no right that the hospital had to deny the parents
24 custody of the child. To have done that, -- laying all
25 these other statutes aside, to have done that would have --

1 as Mr. Todd said, would have amounted to a tort in its own
2 right. So they had -- absent these -- they had an
3 obligation to return the child to the parents when they no
4 longer had a reason to keep the child, a satisfactory reason
5 to keep the child.

6 MR. HOOD: But that's where -- and it's not a duty,
7 it's a violation.

8 THE COURT: And it is -- let me finish. And it's not
9 their -- they have no authority to determine when custody of
10 a child may be denied the parents.

11 MR. HOOD: No. And I'm not saying about custody --

12 THE COURT: It's authority we're talking about here.

13 MR. HOOD: Sir?

14 THE COURT: I'm just talking about authority.

15 MR. HOOD: Well, they could -- and I'll get into it.
16 They could apply, because they're in North Carolina, even
17 though it's a South Carolina case and South Carolina law
18 applies, they've got to utilize the North Carolina law and
19 they could apply to the Court for a twelve to twenty-four
20 hour emergency situation---

21 THE COURT: Max.

22 MR. HOOD: ---and report it to law enforcement -- and
23 report to law enforcement.

24 THE COURT: Okay. The child stayed there for three
25 days for, in quotes, "evaluation", so it exceeded any time

1 imposed by statute when they could have kept the child.

2 MR. HOOD: But the thing is is this is about the safety
3 of a child, Your Honor.

4 THE COURT: Well, I'm talking about -- do you know why
5 that statute exists? They can't keep the child without that
6 statute at all.

7 MR. HOOD: They can't keep the child, but they could
8 apply for that, but this -- and this goes to the duties that
9 they have laid out and he says there's no duty. We've laid
10 out duty after duty after duty with the policies and we've
11 laid out the different -- the social worker standards of
12 care and we're saying that they violated those, because if
13 they had done what they were supposed to do, if the social
14 workers had done what they were supposed to do, there is
15 ample evidence that these were parents that were eighteen
16 years old. These were parents that were at poverty level.
17 They had risk factor after risk factor after risk factor for
18 abusing this particular child and that in -- Kevin Moore,
19 who worked for Charlotte-Mecklenburg Hospital, that's one of
20 our experts. He worked for them.

21 THE COURT: You mean absent of injury, a hospital has a
22 right to keep a child because the parents are poor and
23 uneducated?

24 MR. HOOD: No, but when you have two subdural hematomas
25 and there's no explanation and they can't tell you that

1 there's an explanation and the literature is rife with if
2 you don't have an explanation and you have somebody who's
3 eighteen and you have all these risk factors, one of the
4 most critical elements that you have to have is you have to
5 have an explanation. There was no explanation. They
6 couldn't say, oh, we don't know. Their thing is we don't
7 know how it happened. Well, they also knew --

8 THE COURT: It compares to arson. There's a category
9 of explanations in arson cases that is fire of unknown
10 origin.

11 MR. HOOD: Yes, Your Honor.

12 THE COURT: That's a satisfactory explanation for a
13 fire. We don't know the cause.

14 MR. HOOD: Right.

15 THE COURT: Well, it seems to me that that certainly is
16 much more serious, but --

17 MR. HOOD: But that's criminal, but somebody can sue
18 you civilly.

19 THE COURT: No, that's civil.

20 MR. HOOD: Right, but it can also be criminal and then
21 somebody could sue you for civil,---

22 THE COURT: That's right.

23 MR. HOOD: ---you know, and this is -- this is not a
24 situation -- we're suing civilly.

25 THE COURT: I understand.

1 MR. HOOD: And what I'm saying is that this child, if
2 they had done what they were supposed to do under the duties
3 they owed this child, one, DSS would have had a ton more
4 information, because they would have done what they were
5 supposed to do, laid out by the guy that worked for
6 Carolinas Medical Center, and then it would have allowed DSS
7 -- because you can't always assume that somebody's -- and
8 it's black-letter law that if one doctor does something
9 wrong and it isn't real bad or if somebody's in a car wreck
10 and then the doctor does something and severs their spine,
11 the person that just caused the little back twinge is still
12 responsible for the paraplegia, because the subsequent
13 person -- there's not a break in the intervening -- that's
14 not an intervening negligence. It's foreseeable that
15 somebody can do something that's wrong and in this
16 particular case you have somebody who had a duty, they
17 breached that duty --

18 THE COURT: Well, you're assuming a duty.

19 MR. HOOD: No, Your Honor. We've laid out the duties
20 that they had in this --

21 THE COURT: What are they?

22 MR. HOOD: Sir?

23 THE COURT: What are they?

24 MR. HOOD: They have a duty --

25 THE COURT: Let me say it this way: if you brought

1 your child to my house to play with my kid and I saw your
2 child had bruises about their arms and legs or on their head
3 and the child was kind of woozy, at common law, I have no
4 duty to report that, to do anything. I have no duty to do
5 anything.

6 The duties that have been imposed in this area, which
7 is certainly critical, are duties that are imposed at law,
8 typically, by statute and, in some cases, by case law.
9 Duties are not presumed.

10 If you brought your child to my house and I saw that
11 the child was injured -- to play with my -- or your
12 grandchild and my grandchild -- let's put it that way.

13 MR. HOOD: Right.

14 THE COURT: -- and I saw that the child was injured, do
15 I have a duty to report it? Do I have a duty to do
16 anything? I think that answer's no at common law.

17 The duties that are imposed are duties that are imposed
18 upon people who run a -- who have the ability to -- I guess
19 we've imposed them because we want to impose extra care, to
20 see to the care of protecting children from these kind of
21 things, which in this case happened, but absent that,
22 there's no duty at all. The duty -- and you haven't shown
23 me a duty---

24 MR. HOOD: Your Honor, --

25 THE COURT: ---in these policies that exceeds that.

1 MR. HOOD: I'm not saying that it exceeds it. We're
2 talking about a duty that's separate and independent from a
3 statutory duty.

4 THE COURT: It would be a new duty, in my opinion,
5 under the case law.

6 MR. HOOD: How would it be a new duty if --

7 THE COURT: Because these people did not have care,
8 custody or control of the child, had no right to keep the
9 child.

10 MR. HOOD: But it was admitted, just like it was in the
11 lady that was admitted to the Babcock Center.

12 THE COURT: And you've told me that they exercised
13 extreme care while the child was admitted and kept.

14 MR. HOOD: No, Your Honor. I've laid out that they did
15 not exercise extreme care, not from a social work
16 perspective and that's a violation of a duty.

17 THE COURT: They -- you told me they had a sitter for
18 the child twenty-four/seven.

19 MR. HOOD: Yes, but that is not the social work
20 standard of care we've laid out -- Kevin Moore and we had
21 George Savarese who've laid these specific violations---

22 THE COURT: I will --

23 MR. HOOD: ---of the standard of care.

24 THE COURT: Listen to me.

25 MR. HOOD: Yes, Your Honor.

1 THE COURT: I will grant you that they had a duty while
2 they had the care, custody and control of the child when it
3 was there for evaluation and treatment. They had -- beyond
4 the statutory duty to report, so far as I know, as far as I
5 know, they had no duty to look after the care of the child,
6 which is really what we're talking about, bottom line, after
7 the child was taken from them or dismissed by them. The
8 only question becomes did they comply with the statutory
9 duty in respect to protecting the child as best they could?

10 MR. HOOD: Okay. And just, Your Honor, the -- one of
11 the standards that we're saying that applies in this case --
12 of duty that applies in this case,---

13 THE COURT: Yes, sir.

14 MR. HOOD: ---is a JCAHO standard for provision of
15 care, treatment and --

16 THE COURT: What's JCAHO?

17 MR. HOOD: I'm sorry?

18 THE COURT: JCAHO?

19 MR. HOOD: Yes, Your Honor.

20 THE COURT: What is that?

21 MR. HOOD: It's the Joint Commission of Accreditation
22 of Hospital Organizations.

23 THE COURT: Oh.

24 MR. HOOD: And it requires victims of abuse be
25 assessed, specific criteria be developed for child abuse

1 cases and appropriate staff is educated on how to address
2 abuse cases.

3 In our -- there's also, Your Honor, we contend, a duty
4 while the child is there under the care of Carolinas Medical
5 Center. There's a duty to --

6 THE COURT: I assume these parents signed a permission
7 -- a written permission for the treatment for the child; did
8 they not?

9 MR. HOOD: Sure, but we say there's a need to access,
10 communicate, intervene and document in regard to the social
11 work aspect of this particular child.

12 THE COURT: Why do you say that?

13 MR. HOOD: Sir?

14 THE COURT: Is there a South Carolina case that holds
15 that?

16 MR. HOOD: There's a South Carolina case that says they
17 owe a general duty of care.

18 THE COURT: That's the Babcock case.

19 MR. HOOD: Yes, Your Honor.

20 THE COURT: Well, that person was in the care, custody
21 and control of Babcock -- not Bab- -- the Department and the
22 injuries happened while that person was in the care, custody
23 and control of the institution.

24 MR. HOOD: Right, but the thing is, Your Honor, the --
25 whether the injury occurred while they were in the care,

1 custody and control should be irrelevant if the duty applied
2 while they're within the care, custody and control.

3 THE COURT: There we disagree.

4 MR. HOOD: Why is that, Your Honor? Because negligence
5 is --

6 THE COURT: I don't have to explain to you why, I just
7 don't think it's the law.

8 MR. HOOD: Well, I think that the law is negligence is
9 duty -- breach of duty and damages.

10 THE COURT: That's correct.

11 MR. HOOD: And it doesn't have to be within twelve
12 hours, it could be something that is -- could be thirty days
13 apart and that gets into causation, whether there's -- you
14 know, but for causation or foreseeability.

15 THE COURT: They complied -- the only thing that they
16 had was that statutory duty unless -- except when the child
17 was in the care, custody and control of the hospital.

18 MR. HOOD: Okay.

19 THE COURT: Okay. It appears to me -- and, hopefully,
20 it appears that I've read this material. It appears to me
21 that they -- the only additional duty was a duty to report
22 to try to prevent injury to the child after they had care,
23 custody or control of the child. It appears to me they
24 complied with that duty---

25 MR. HOOD: I would --

1 THE COURT: ---and they associated the very agency that
2 has to deal with it.

3 MR. HOOD: I agree that they complied with their duty
4 to report. What I don't agree with is that they -- there
5 was a duty -- and while the duty of care was -- they had
6 this duty of care while the child was in their custody and
7 control. The social worker --

8 THE COURT: To see that the child was not injured while
9 in their care, custody or control.

10 MR. HOOD: Not to see whether the child was injured,
11 but to do what was supposed to be done under a general duty
12 of care, which is assess, document, intervene, the things
13 that we've talked about and, in fact, Your Honor, you have a
14 situation where one of the things -- another case that they
15 have cited, and this is my case, is the Faile case. It says
16 -- and Mr. Todd cited this in his brief. There's the Faile
17 case, Your Honor.

18 Under the Faile case, it says that under South Carolina
19 law, there's no general duty to control the conduct of
20 another or the one of a third person or potential victim of
21 danger and then it has -- it recites the statement of 314
22 and then it gives five exceptions to that. It says, we
23 recognize five exceptions: where the defendant has a
24 special relationship to the victim. That didn't occur in
25 this particular case, but where the decedent has a special

1 relationship to the injurer, and in that particular case, if
2 you go to that specific footnote, --

3 THE COURT: Which is where? Which footnote? I don't
4 see any footnotes.

5 MR. HOOD: I'm sorry, Your Honor. It's right here.
6 They put them right in the middle of the page sometimes.

7 THE COURT: Which page are you on?

8 MR. HOOD: I'm sorry, Your Honor. Page thirteen.

9 THE COURT: All right.

10 MR. HOOD: One, it says, there's no duty to control the
11 conduct of a third person to prevent him, unless a special
12 relationship exists between the actor and the other, which
13 gives the other a right to protection. When a person is in
14 a position to monitor, supervise and control a person's
15 conduct, the special relationship between the defendant and
16 the dangerous person may trigger a common-law duty to warn
17 potential victims of the danger. That isn't it, but what
18 you have is where the defendant voluntarily under case of
19 duty.

20 In this particular case, they had social workers that
21 came into the room, did a very specious -- they, basically,
22 said, what's your name, how are you doing and they did not
23 do what they were supposed to do. They undertook the duty
24 to perform that social work role, but they didn't do it in a
25 responsible manner or in a manner that was supposed to be

1 done and under the Faile case, and it's just black-letter
2 law --

3 THE COURT: Wasn't DSS doing that?

4 MR. HOOD: No. It was also -- it was both, Your Honor.
5 It's a joint responsibility. DSS was doing it and we've
6 sued DSS for that, but there's a joint responsibility,
7 because it was also the hospital that was doing it.

8 THE COURT: Where is the protocol or algorithm for what
9 a social worker's supposed to do?

10 MR. HOOD: We have -- Your Honor, we have two. We have
11 the protocol that says that there's not supposed to be a
12 discharge until, basically, social work and --

13 THE COURT: DSS.

14 MR. HOOD: -- and DSS agree.

15 THE COURT: And apparently they did.

16 MR. HOOD: Well, the thing is, though, if they did and
17 they did it wrong, then there is a duty and we're saying
18 that they violated that duty. That's what we're saying, is
19 that they violated that duty, because they owned it jointly.

20 THE COURT: Violated it how?

21 MR. HOOD: Because they allowed this child to be
22 discharged and they couldn't say -- Your Honor, here's a
23 child with two subdural hematomas and they say -- they,
24 basically, throw up their hands. We don't know whether it
25 is or it's not, but you all have these risk factors and

1 everything else and the doctor herself said it's a coin
2 flip.

3 THE COURT: And they disclosed all that?

4 MR. HOOD: They disclosed that the child was medically
5 stable to be discharged, but medical discharge is different
6 than social discharge. There -- you have to -- in a case of
7 child abuse, the policy and procedure and also the joint
8 commission and also the social worker, the standards of care
9 in the industry from -- that are applicable in this case by
10 the National Association of Social Workers, they all say
11 that you have to do a proper assessment. There was not a
12 proper assessment done in this particular case. If there
13 was a proper assessment done, you would have been able to
14 give a lot more information, because, honestly, -- and no
15 offense to DSS, but we've alleged that they were grossly
16 negligent.

17 THE COURT: All right. The only thing that I want to
18 hear anymore about is from Mr. Todd about this social worker
19 business.

20 MR. HOOD: Okay.

21 THE COURT: I understand your position.

22 MR. HOOD: Yes, Your Honor. Thank you.

23 MR. TODD: Your Honor, the social worker in this case,
24 called DSS, reported --

25 THE COURT: Tell me who the social worker is?

1 MR. TODD: The social worker was Laura Neumark.

2 THE COURT: And she works for CMC?

3 MR. TODD: Yes, sir.

4 THE COURT: All right.

5 MR. TODD: And she would take information from the
6 doctors, provide it to DSS.

7 THE COURT: Yeah.

8 MR. TODD: She reported to DSS this child -- the
9 doctors have not been able to definitively rule in or rule
10 out child abuse.

11 THE COURT: What else does her job description require
12 her to do with respect to a child where an evaluation like
13 that is done?

14 MR. TODD: Well, she's supposed to get the information
15 from the doctors and provide it to CMC.

16 THE COURT: What else?

17 MR. TODD: Your Honor, that is --

18 THE COURT: What about dealing with the child?

19 MR. TODD: They did take a history from the child.
20 They did observe the child---

21 THE COURT: Who did?

22 MR. TODD: ---in the room with the parents. Social
23 workers, doctors, nurses.

24 THE COURT: All the above?

25 MR. TODD: Well, your Honor, they were in the room with

1 the -- they were in there with the child.

2 THE COURT: My question is -- my question is what does
3 -- let me say it this way: is there a hospital policy that
4 defines what it is a social worker is supposed to do in such
5 a case where there is no -- where there's no medical finding
6 that there's been child abuse?

7 MR. TODD: No, sir. He points to the algorithm, policy
8 or procedure, whatever it is, where the social worker is
9 supposed to clear a discharge --

10 THE COURT: Here's what it says, when medically
11 cleared, do not discharge child until disposition has been
12 determined by medical social worker and DSS.

13 MR. TODD: Well, the social worker, when she was
14 deposed, said it's my duty, it's my responsibility to
15 contact DSS and find out what kind of discharge provisions
16 they want us to do. You know, it gets back to, I think you
17 said, they have no authority to detain this child. It's set
18 forth in the statute and --

19 THE COURT: So if she disagreed -- if the social worker
20 disagreed with DSS, the hospital would be in the position of
21 trumping DSS by keeping the child, which---

22 MR. TODD: We don't --

23 THE COURT: ---in other words, if she says, I disagree
24 with them and it says determined by medical social worker
25 and DSS, this social worker would be, essentially, trumping

1 DSS's opinion and advising the hospital to keep the child?

2 MR. TODD: I guess if that were the situation, then
3 we'd have to -- they still have no authority to detain the
4 child, absent authority for some state agency or court.

5 THE COURT: Or in this case, a North Carolina statute.

6 MR. TODD: For twelve hours, Your Honor.

7 THE COURT: Yes.

8 MR. TODD: And then the immunity statute that has not
9 been addressed and the immunity statute is clear, if you
10 participate in the investigation, which is what was done in
11 this case, and obviously there's a policy, they do want
12 persons who report to participate in the investigation and
13 there's immunity for that, absent bad faith, which, in this
14 case, there's no allegation of bad faith. There's no
15 pleading, there's no proof. So there's no duty and there is
16 immunity.

17 THE COURT: So if DSS said -- all right. Let me ask
18 Mr. -- Mr. Hood?

19 MR. HOOD: Yes, Your Honor.

20 THE COURT: If DSS said, release the child and the
21 social worker said, do not release the child, would not the
22 hospital be in violation of the law by keeping the child?

23 MR. HOOD: No, Your Honor. They could apply to the
24 courts to hold the child and that would trigger an automatic
25 reporting to law enforcement and that would start a whole

1 different thing in regard to --

2 THE COURT: Well, DSS reported it to law enforcement;
3 did they not?

4 MR. HOOD: Not on the 8th, they didn't. They didn't
5 report it to law enforcement until the 17th.

6 THE COURT: I thought somebody said that a few minutes
7 ago.

8 MR. HOOD: No and, in fact, when the -- we've got the
9 recording of the call from law enforcement and law
10 enforcement, what they said was, you've got to be kidding
11 me. You're telling me now, on the 17th, with a child who
12 has two subdural hematomas and we're just getting this now
13 and this happened eleven days ago? And, Your Honor, I want
14 to hand this up. Here's that policy. I just wanted Your
15 Honor to see that. There's the policy and it also says that
16 there has to be a safety plan on the chart in writing.

17 THE COURT: If applicable.

18 MR. HOOD: If applicable. In this case it was
19 applicable.

20 THE COURT: They didn't know it was applicable.

21 MR. HOOD: Yeah, they knew it was applicable. They
22 admitted that it was supposed to be on the safety -- it was
23 supposed to be on the chart.

24 THE COURT: Well, what was the plan?

25 MR. HOOD: We've gotten different testimony about that,

1 Your Honor, discharge to the parents. Your Honor, here's a
2 --

3 THE COURT: Wait. Let me just read one thing.

4 MR. HOOD: Yes, Your Honor. I'm sorry.

5 THE COURT: So what we're getting down to is is
6 whether, as a matter of law, the hospital had a duty to
7 retain custody of the child?

8 MR. HOOD: Or, Your Honor, here's this from the doctor
9 on 12/7/08 --

10 THE COURT: Am I right or wrong?

11 MR. HOOD: That says that's it okay to discharge under
12 supervision.

13 THE COURT: Was not DSS supervising?

14 MR. HOOD: Your Honor, they didn't even go see the
15 family, I think, until probably the 17th or the 21st.

16 THE COURT: Well, the hospital doesn't know what DSS
17 will do. They know DSS is a state agency that's supposed to
18 be looking after children. DSS could be negligent apart
19 from the hospital.

20 MR. HOOD: Yes, or in conjunction with the hospital and
21 it certainly -- it isn't on the chart. We can't find it on
22 the chart anywhere.

23 THE COURT: So the question is whether there's a
24 genuine -- this is a summary judgment motion. The question
25 is whether there's a genuine issue of fact concerning

1 whether DSS failed -- I'm sorry -- whether CMC failed to
2 retain custody of the child---

3 MR. HOOD: Or --

4 THE COURT: ---after, A, they couldn't medically say
5 that the child had been abused and, B, DSS had cleared them
6 to release the child.

7 MR. HOOD: I think there's more than that, Your Honor.
8 I think there's also a duty to assess and they didn't do
9 that properly. I think that that is in there, too, but if
10 we even take Your Honor -- if we took what Your Honor said,
11 we've presented affidavits, not about the duty, but about --
12 we've produced a scintilla of evidence in that regard.

13 THE COURT: What is that?

14 MR. HOOD: Whether there was a violation of that duty
15 or not.

16 THE COURT: But that presupposes a duty.

17 MR. HOOD: No, no, Your Honor. I'm just answering your
18 question. You said -- your question was --

19 THE COURT: What is the scintilla of evidence that they
20 violated the duty?

21 MR. HOOD: We've presented affidavits with -- one is
22 seven pages, one is thirty pages, talking about the duty
23 that they violated in this particular case.

24 THE COURT: Okay. I've heard enough. I'm going to
25 grant the motion. I believe that there is a genuine issue

1 of fact whether CMC fulfilled its duty. I construct that
2 from the proposition that they complied with the law. They
3 were advised by the appropriate state agency that the child
4 should be released and that there's no -- certainly no issue
5 of fact that they exercised care under the Babcock case for
6 the child while the child was in the custody of the
7 hospital.

8 What we're talking about is the duty to retain a child
9 when they had no legal right and could not support what they
10 were doing medically. So I'm going to grant the motion.

11 Mr. Todd, you need to email me, in Word format, a
12 proposed Order.

13 MR. TODD: Yes, sir.

14 MR. HOOD: Your Honor, just for the purpose of --

15 THE COURT: Put anything on the record you want to.

16 MR. HOOD: Your Honor, as far as we -- of course, we'll
17 do the 59(e) thing after that, but what would be the --
18 because this is so intertwined with DSS and everything else,
19 from an interlocutory standpoint, would it be you or Judge
20 Hayes that we would be applying -- making a motion for
21 interlocutory appeal in this case?

22 THE COURT: I supposed it would be Judge Hayes.

23 MR. HOOD: Okay.

24 THE COURT: The 59(e) would come here. I don't know.

25 Ask somebody. Look at the rule. I don't know the answer to

1 that question off the top of my head.

2 MR. HOOD: Okay. Thank you.

3 MR. TODD: Your Honor, just one housekeeping matter.

4 We had -- Mr. Hood and I talked about -- we presented and
5 I've referenced a number of depositions, Mr. Hood presented
6 voluminous materials. What we were going to do is, if that
7 motion were granted, file those with the clerk at that time.
8 So do we do that here?

9 THE COURT: No, not here. You do that down the street.

10 MR. TODD: Okay. Thank you.

11 THE COURT: Where there is still no courthouse.

12 MR. TODD: Yes.

13 THE COURT: Yeah. And what all are you going to file
14 now?

15 MR. TODD: The depositions that we've referenced. I
16 mean, I think they set for the facts and --

17 THE COURT: I need to file all of this, 'cause I'm
18 going to eventually send all this back.

19 MR. TODD: Okay. I think that's Mr. Hood's.

20 THE COURT: It is.

21 MR. HOOD: We can just jointly go down and file --

22 MR. TODD: We can just go and get that done.

23 THE COURT: I need to -- I'm going to keep the basic
24 file, 'cause I got to -- if I have to tweak, you know, tweak
25 the Order as I see fit. I'm going to keep this. I suppose

1 I need to keep this.

2 MR. TODD: We'll work together and just file what we've
3 agreed upon and --

4 THE COURT: Especially -- well, if he's going to do a
5 59(e), I need to keep it anyway, so -- all right. Anything
6 else?

7 MR. TODD: That's all, Your Honor.

8 THE COURT: Thank you.

9 MR. HOOD: Your Honor, very -- just for the purposes of
10 the record, to keep something for 50(E), we would have said
11 that in regard to the immunity issue, that that only goes to
12 the reporting and for somebody getting sued for liable
13 defamation and that kind of thing and there's a case called
14 Williams versus Babcock, where they address that and if Your
15 Honor ruled on that, then that's something that was raised
16 and that way -- or we can address it on a --

17 THE COURT: So what you're saying is does immunity mean
18 immunity from violation of a common-law duty, essentially?
19 Separate and apart from a common-law or statutory duty?

20 MR. HOOD: Yes.

21 THE COURT: To the extent -- do you agree with that,
22 Mr. Todd?

23 MR. TODD: I got distracted, Your Honor.

24 THE COURT: Well, I understand. Let me say it this
25 way: to the extent the -- yeah. We're not through. I'm

1 sorry, Randy. I didn't -- we didn't address that properly.

2 The immunity, as I understood Mr. Todd's argument, is
3 based upon 63-7-390, which is premised on 67- -- I'm sorry
4 -- 63-7-310, all of which has to do with a duty to report
5 and upon reporting, gives immunity from civil liability as
6 well as criminal, but civil liability.

7 MR. HOOD: For the reporting function?

8 THE COURT: Excuse me?

9 MR. HOOD: For the reporting function, Your Honor?

10 THE COURT: Yes.

11 MR. HOOD: Yes, sir.

12 THE COURT: Well, no, no, no. Let me complete -- for
13 the reporting agency and that immunity extends to full
14 disclosure by the person of facts which gave the person
15 reason to believe that the child's physical or mental health
16 or welfare had been or might be adversely affected by abuse
17 or neglect.

18 My view of that is that construing that statute in
19 context and the proper parameters applies to immunity for
20 reporting only. I do not believe that one could claim
21 immunity from civil liability for a violation of a duty
22 separate and apart by claiming under the statute. Does that
23 answer the question?

24 MR. HOOD: Yes, Your Honor. Thank you.

25 THE COURT: So that, in essence, Mr. Hood's argument

1 about the other duties and whatnot, I believe would be
2 unaffected by 63-7-390 by a narrow reading of that statute
3 as it's written. Does that answer your question?

4 MR. HOOD: Thank you, Your Honor. Yes.

5 MR. TODD: Your Honor, it wasn't -- I know that it
6 wasn't set out,---

7 THE COURT: Yes.

8 MR. HOOD: ---but anyway,---

9 THE COURT: Well, you didn't win that one.

10 MR. TODD: I know, but I will address it. The statute
11 says a person required or permitted to report,---

12 THE COURT: Yeah.

13 MR. TODD: ---pursuant to the reporting statute,---

14 THE COURT: Yeah.

15 MR. TODD: ---or who participates in an investigation.
16 So a lot of Mr. Hood's argument goes to the participation of
17 the social worker in the investigation, participating with
18 DHEC. So when you read in the or who participates, that
19 brings this immunity statute into play and makes it
20 applicable in this case.

21 THE COURT: Unless not acting in good faith?

22 MR. TODD: Yes, sir.

23 THE COURT: What about that, Mr. Hood?

24 MR. HOOD: Your Honor, this is all about the reporting
25 function. If they had to do an investigation or participate

1 in something before making their report and whatever they
2 had to do to make a report, I agree they're entitled -- for
3 everything that had to do with the reporting, they're entitled
4 to immunity for that, but this is all post-reporting conduct
5 that we're talking about here.

6 THE COURT: No. It says investigation.

7 MR. HOOD: Yes, Your Honor, but it's also talking about
8 in the reporting function and it's under the reporting part
9 of that --

10 THE COURT: No. I disagree with that. It says, a
11 person who is required to report or who participates in an
12 investigation.

13 MR. HOOD: In an investigation to make the report, Your
14 Honor. They're just --

15 THE COURT: No, it doesn't say that.

16 MR. HOOD: Okay. Your Honor, I'll show you a case.
17 It's called Williams versus Babcock. Let me find it.

18 THE COURT: I think I can save you some time.

19 MR. HOOD: Yes, Your Honor.

20 THE COURT: I think, in any event, your claim is that
21 the investigation would have been made not in good faith to
22 the extent, I mean, that the social worker what she was
23 absolutely, according to your side of the story, your side
24 of the case, absolutely demanded to do under proper facts?

25 MR. HOOD: That is correct, Your Honor. Good faith and

1 violates the standard care in doing what she was supposed to
2 do, Your Honor.

3 THE COURT: But this -- that statute protects people
4 who are not -- are -- upon which -- there is no imposition
5 of a duty to report, I think. So in other words, a private
6 social worker, not an employee of the hospital who had no
7 duty -- and if we assume that the hospital had called in a
8 private social worker, somebody in private practice or a
9 psychologist, whatever, and had them do an evaluation and
10 that person made the report, a written summary of their
11 evaluation, not a report of child abuse, as required by
12 statute, I believe that person is also protected, because
13 that person has made defamatory remarks, if the remarks are
14 not true. Actually, it's libelous, because it's a written
15 report.

16 MR. HOOD: And I think that's what that Williams case
17 says is it was a case where somebody went in, they had said
18 something and then the social worker had given it to a
19 psychologist to review, the psychologist had done an
20 investigation or had done a counseling session with somebody
21 who is a vulnerable adult, somebody mentally retarded, and
22 then the social worker then spoke with the psychologist who
23 had done that and so the social worker and psychologist had
24 decided, okay, it needs to be reported. Social worker makes
25 the report, she gets sued for liable and defamation. The

1 reporting only. Hold on a minute.

2 Let me just say it this way: I don't think the statute
3 -- I'm going to go back to what I said originally. I don't
4 believe the statute shields the hospital or anybody else for
5 other duties they might have had apart from the reporting
6 process.

7 I'm going to deny summary judgment based on the
8 immunity statute. Well, there's -- are you claiming there's
9 any liability under the statute?

10 MR. HOOD: No, Your Honor.

11 THE COURT: Okay. We'll leave it there.

12 MR. TODD: Yes, sir.

13 THE COURT: Thank you.

14 MR. TODD: I will send the Order to Mr. Hood for review
15 before I send it --

16 THE COURT: As he will tell you, I'm going to tweak it
17 to suit what I want it to say.

18 MR. TODD: Send it to you and Mr. Hood at the same
19 time?

20 THE COURT: Send it simultaneously. Yeah.

21 MR. TODD: We'll do it.

22 THE COURT: Okay. Thank y'all.

23 MR. TODD: Thank you.

24 MR. HOOD: Thank you, Your Honor.

25 (END OF REQUESTED TRANSCRIPT)

STATE OF SOUTH CAROLINA
COUNTY OF YORK

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) C E R T I F I C A T E
)

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

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

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


Shannon E. McGilberry

My Commission Expires:

April 16, 2017

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

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

Reported by
Susan A. Wyant

APPEARANCES

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

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EXHIBITS

No exhibits were marked during this hearing.

P R O C E E D I N G S

1
2 MS. CASEY: If it may please The Court, again, my name
3 is Debra Casey. I am here on behalf of the
4 plaintiff with respect to this motion to reconsider
5 your prior order. Your Honor, the -- upon review
6 of the transcript and some other -- and the other
7 materials that were covered in the prior motion for
8 summary judgment, the plaintiff believes that The
9 Court previously erred in its granting of summary
10 judgment and that there is a reason to reconsider
11 and reverse or amend the prior ruling.

12 And if -- do I need -- or would you like for
13 me just to refresh the facts, Your Honor, with
14 respect to the case, or are you still --

15 THE COURT: I don't think so. I -- I'm -- this young --
16 young child was presented at -- at the Levine
17 Children's Hospital in -- with an injury. They
18 determined that he had a subdural hematoma. They
19 notified the Department of Social Services. They
20 did a further evaluation of the child. They held
21 the child for, I think, three or four days before
22 releasing -- releasing the child, medically, back
23 to his parents. And in conjunction with that, DSS
24 advised them to release the child back to the
25 parents.

1 MS. CASEY: Your Honor, I believe that is a -- a
2 statement of the facts, but -- but I -- we
3 believe --

4 THE COURT: Add --

5 MS. CASEY: -- that --

6 THE COURT: -- anything you want to.

7 MS. CASEY: Well, we believe there is more -- more to
8 the -- more to the story, if you will, on this.

9 THE COURT: I know you do.

10 MS. CASEY: I believe there was some question with
11 respect to the initial transfer of Owen to the
12 Levines Children Hospital from Piedmont. And the
13 reason he was transferred is that they had done a
14 lumbar puncture and he was found to have some blood
15 in the spinal fluid.

16 THE COURT: Uh-huh.

17 MS. CASEY: And that is an abnormal finding for a child
18 or -- or an adult, and as a result of that, he was
19 transferred to this -- this more specialized
20 facility. And once he was admitted to Levine,
21 there was an additional workup done that did reveal
22 that he had these subdural hematomas. That raised
23 an index of suspicion of child abuse with the
24 caregivers at Levine Children's Hospital, which set
25 in motion a set of -- of activities pursuant to

1 their policies and pursuant to the -- the South
2 Carolina statute.

3 And the defendants in the case would have you
4 believe that the duty to report was the only duty
5 that the hospital had in this particular case and
6 they did comply with that. I believe, when Mr.
7 Hood was here, we -- we agreed that they -- that
8 "they," being Levine, did comply with the duty to
9 report to the DSS, and a DSS representative was
10 sent to the -- to the hospital to talk to the
11 parents and -- and health care providers.

12 But in this particular case, I think what you
13 have is you have a patient who's voluntarily
14 admitted to a health care facility, and by virtue
15 of that voluntary admission as a patient, that
16 gives rise to a legal duty to treat that patient
17 with reasonable care.

18 Now, that reasonable care sort of takes a --
19 two different prongs. The first is the medical
20 care, where we're doing the evaluations, the scans,
21 the blood work, and things of that nature. But in
22 this case, Levines Children's Hospital --

23 THE COURT: Now, there's never been any issue raised
24 concerning the medical care.

25 MS. CASEY: No, Your Honor, there is no -- no issue

1 raised with regard --

2 THE COURT: All right.

3 MS. CASEY: -- to the medical care that was provided by
4 the -- the hospital --

5 THE COURT: All right.

6 MS. CASEY: -- and the -- the physicians.

7 But the -- the -- the example here is that
8 there -- it's -- there are really two components to
9 this: the medical care and then the psychosocial
10 assessment or the social work assessments that were
11 done.

12 Owen was admitted voluntarily. The parents
13 signed a consent that they would allow him to stay
14 in the hospital and would not discharge him until a
15 physician said that he was medically ready to be
16 discharged.

17 THE COURT: Nobody's ever raised that before.

18 MS. CASEY: That -- it -- it -- there is a consent in
19 the record that -- that they signed, and they were
20 asked to sign.

21 THE COURT: Was it presented to me before?

22 MS. CASEY: I believe it was in the medical records,
23 Your Honor, but I -- I do not have that --

24 THE COURT: All right.

25 MS. CASEY: -- consent with --

1 THE COURT: That's all right.

2 MS. CASEY: -- me.

3 THE COURT: Go ahead.

4 MS. CASEY: I -- I don't believe that Mr. Todd will
5 dispute that, that -- that they were asked to do
6 that and --

7 THE COURT: Well, does --

8 MS. CASEY: -- and that --

9 THE COURT: -- it add anything to the argument? I mean,
10 we know that the child was -- was treated and
11 medically -- ultimately, medically released at --

12 MS. CASEY: Well, I think it adds something in the -- to
13 the degree that it --

14 THE COURT: You're trying to say that the consent was a
15 consent for the -- for the hospital to -- to retain
16 the child against the parents' wishes?

17 MS. CASEY: No, Your Honor. I'm not saying that at all,
18 because I don't believe today's argument is in
19 respect to the -- the release of the child. This
20 goes back to before the -- the release was even
21 considered. And this was a question that The Court
22 had previously as to whether there was a duty owed
23 to Owen, other than the duty to report. And it's
24 our contention and our position, and I believe that
25 the -- the facts in the case support that he was a

1 patient at the hospital, and there was a special
2 relationship between this hospital and this -- this
3 patient, which gives rise to a duty to provide
4 appropriate care and treatment. And part of that
5 appropriate care and treatment is the psychosocial
6 evaluation.

7 The hospital took it upon themselves to assign
8 a social worker, or several social workers, from
9 the maltreatment care team who have special
10 training in identifying the child abuse, or
11 potential child abuse, which that suspicion had
12 already been raised.

13 Ms. Newmark testified in her deposition that
14 she had a number of years of experience and that
15 she was trained to recognize child abuse. So she
16 has it -- has that special training and knowledge.
17 The hospital voluntarily assigned these folks, as
18 part of their program and their standards of care,
19 to do a psychosocial assessment.

20 Our -- our --

21 THE COURT: Was that assessment completed?

22 MS. CASEY: That is the core question. There is a --

23 THE COURT: No. It's --

24 MS. CASEY: Whether or not it --

25 THE COURT: -- it's my question. What -- was it -- what

1 -- factually, was the assessment completed?

2 MS. CASEY: Her assessment was performed. It is our
3 contention that it was not performed and it was not
4 completed in a manner that comported with the
5 standard --

6 THE COURT: Did it --

7 MS. CASEY: -- of care.

8 THE COURT: -- result in a -- in a recommendation or a
9 conclusion?

10 MS. CASEY: It did not. It did not result in any
11 conclusions. Her -- her role, as she says in her
12 deposition, was to simply --

13 THE COURT: How about --

14 MS. CASEY: -- report --

15 THE COURT: -- findings?

16 Ms. CASEY: Her findings were that the family had some
17 risk factors, that they -- that the parents were
18 young, not married, and that the findings were that
19 -- that, based on what the -- the hospital
20 physician said, that the child could be discharged
21 when medically stable, but there needed to be a
22 coordination between the social worker and the DSS
23 representative for --

24 THE COURT: And there was.

25 MS. CASEY: I don't think that -- I think that's a

1 question of fact that we do not have the answer to,
2 Your Honor.

3 THE COURT: Well, the -- the -- the D -- is -- it's --
4 it is not a question of fact whether DSS performed
5 its own evaluation and either ordered or -- I've
6 got a -- I'm not sure that's the right word -- but
7 directed the release of the child or authorized the
8 release of the child to the parents.

9 MS. CASEY: Your Honor, that authorization was premised
10 upon consultation with the -- the employees of the
11 hospital with respect to findings. And that is the
12 crux of the case in terms of this issue, is that it
13 is the plaintiff's contention that the findings
14 were not significantly -- or the -- the facts and
15 circumstances surrounding the psychosocial
16 background of this family and the -- and the child
17 was not sufficiently explored by the hospital to
18 provide enough information to the DSS in order for
19 DSS to make an informed decision about whether or
20 not this child should have been released to the
21 parents.

22 THE COURT: Well, let me ask you this. And here's
23 what's -- what's always -- let's -- let's assume
24 that -- that the hospital and -- and the social
25 worker -- the social worker rendered an opinion or

1 was of the opinion that the child had been abused,
2 that the injury -- that the -- that is, that the
3 injury was a result of -- of child abuse, but that
4 DSS disagreed and authorized -- authorized and
5 directed the release of the child to -- to the
6 parents. Are you saying, then, that -- that --
7 that the hospital had a duty to retain the child
8 anyway?

9 MS. CASEY: Well, I think the hospital had a duty to set
10 forth some -- or to set in action some -- some
11 action that could have either called in the
12 authorities -- I -- I don't want --

13 THE COURT: The authorities were called in.

14 MS. CASEY: Well, the --

15 THE COURT: That's why the sheriff's department was made
16 a party to this case.

17 MS. CASEY: Well, the -- the authorities were not called
18 in by the hospital.

19 THE COURT: No.

20 MS. CASEY: They were called in by DSS --

21 THE COURT: By DSS.

22 MS. CASEY: -- after this child had already been
23 released from the hospital.

24 But, Your Honor, this -- the -- my argument
25 today does not go to the authority of DSS to remove

1 this child from the hospital. My argument today
2 goes to a duty that they -- that this hospital owed
3 to Owen to form -- to perform adequate and -- and
4 proper psychosocial assessments and to obtain the
5 information that was necessary to go into the
6 overall plan, and they were to participate in this
7 discharge plan. There's no indication that the
8 social worker from the hospital ever even
9 participated, really, in the discharge plan. All
10 she did was report that, "We can't decide whether
11 this was non-accidental trauma or not."

12 THE COURT: Well, isn't that a decision?

13 MS. CASEY: That's not a decision --

14 THE COURT: Why isn't --

15 MS. CASEY: -- Your Honor.

16 THE COURT: -- it?

17 MS. CASEY: It's not a decision. It's -- it's a
18 reporting.

19 THE COURT: If I --

20 MS. CASEY: But it says --

21 THE COURT: If I render a decision denying summary
22 judgment and say, "Well, I think there's an issue
23 of fact. I -- I don't know -- I don't know what
24 the facts are. I think there may be an issue of
25 fact," isn't that a decision?

1 MS. CASEY: Well, that's the -- is a decision, but this
2 is a -- this is -- it is a -- on a different level
3 in terms of this social worker had the -- the
4 training and the skills to have input. And there
5 was no input into the DSS's decision with respect
6 to: "We have done an investigation, which we're
7 obligated to do under our policies, that says,
8 'What, really, are the circumstances of this child?
9 What are the socioeconomics? What are the risk
10 factors?'" That was never done and reported to
11 DSS, and that is an independent responsibility
12 apart from DSS. If DSS never --

13 THE COURT: But in the end, though, Ms. Casey, let's
14 assume they did all of that and DSS said, "Oh, no.
15 No. We think -- you know, thank you for your help.
16 It's a closed question, but release the child to
17 the parents."

18 MS. CASEY: Well, that's presuming that DSS is going to
19 do that.

20 THE COURT: DSS did do that.

21 MS. CASEY: Well, that is -- again, that's presuming
22 that DSS did that. But, again, that's an issue for
23 DSS, whether they did that or not.

24 THE COURT: No, ma'am. How can I -- I -- in -- in
25 the -- the -- to -- I can't get over this -- this

1 hump in my mind that says that -- that -- that --
2 that nobody has a right to retain custody of
3 somebody else's child, absent a court order, and,
4 upon direction, to release the child by the South
5 Carolina Department of Social Services.

6 MS. CASEY: Well, again, Your Honor, it doesn't go --
7 this argument doesn't go to that, and I understand
8 where you're -- you're --

9 THE COURT: I know your argument doesn't go to that, but
10 doesn't that cancel the argument?

11 MS. CASEY: No, Your Honor, it doesn't. Because
12 presuming that Mrs. Nemark or -- or the other
13 social workers that were involved had done the
14 appropriate assessment, I think that it is fair and
15 it's a question of fact for the jury to determine
16 that if that had been done, a reasonable social
17 worker would have never made the decision to remove
18 that child. So it would have been taken out of --
19 it would not have been in the hospital's hands to
20 begin with.

21 THE COURT: But DSS made its own call about that.

22 MS. CASEY: They made their call based on interactions
23 with the hospital. It was not an independent call
24 just saying, "We're making this" -- their -- their
25 investigation had just started the day -- just

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1 shortly before this child was released from the
2 hospital.

3 The social workers over that four-day period
4 of time were in the best position to observe the
5 family, to interview the family, to interview
6 family -- other family members, and to find out the
7 status of the socioeconomics, what the risk factors
8 were, and that was never done. It clearly was done
9 by DSS and the hospital after the child was
10 catastrophically injured, but those systems were in
11 place during this first hospitalization. They were
12 not utilized. They were not undertaken, and as a
13 result of that, inadequate information was given to
14 a department that made a decision to remove this
15 child from the hospital and give him back --

16 THE COURT: What was inadequate?

17 MS. CASEY: Inadequate --

18 THE COURT: What was inadequate?

19 MS. CASEY: The inadequate information.

20 THE COURT: Yes, ma'am.

21 MS. CASEY: The inadequate information was that the -- a
22 nurse had reported that she had spoken with the
23 grandmother in a private manner and that the
24 grandmother had been concerned about the -- there
25 being some bruises on the child earlier. The

1 inadequate information with respect to -- there was
2 no information gained with respect to the job
3 status of the -- the mother, the father. There was
4 no information gained with respect to any
5 concerns --

6 THE COURT: What did that have to do with child -- with
7 the claim with child abuse?

8 MS. CASEY: All of that goes into risk factors that are
9 to be considered and taken in -- or taken into
10 consideration when one is doing an evaluation,
11 especially in light of --

12 THE COURT: Whether or not mother and father have a job?

13 MS. CASEY: Yes, sir. They do because that creates
14 stresses in the family --

15 THE COURT: I see a lot of those most every day.

16 MS. CASEY: Well, it creates stresses in the family, and
17 it may not -- it does not necessarily predispose
18 anyone to -- to abuse their child, and I am not
19 saying that, whatsoever. But what I am saying is
20 that is a risk factor that goes into an assessment
21 and is to be taken into consideration in light of
22 all the other facts that are in the case.

23 And in this particular case, we had an
24 unexplained injury. The parents did not have a
25 reasonable explanation for how the injury happened.

1 We have children -- basically, children having
2 children. These were very young parents, 18 and
3 19. They were not high school graduates. They
4 were living, I think, within the poverty level or
5 the definition of the poverty level. The hospital
6 was even concerned that they had poor parenting
7 skills. And then you have a child who has an
8 injury that's unexplained and is potentially an
9 injury that was caused by abuse from somewhere.
10 And there was no investigation from the hospital to
11 determine if these parents were really at -- at
12 risk for injuring this child either --

13 THE COURT: But look. Isn't the bottom line that the
14 hospital had to render an opinion looking at the
15 injury to the child and be able to say to -- to a
16 reasonable degree of medical certainty -- that
17 would be the standard if you sued them for
18 malpractice on the medical end -- that this injury
19 was most probably caused by child abuse?

20 MS. CASEY: I think that -- that -- that --

21 THE COURT: And they could not say that.

22 MS. CASEY: They could not say that. You're right.

23 THE COURT: Well, then, what are they to do? If they
24 can't say -- if they can't relate the injury to the
25 risk factors that -- poverty, young, single,

1 unemployed -- if they can't relate the injury to
2 the risk factors, how can they possibly hold the
3 child?

4 MS. CASEY: And, Your Honor, I'm not talking about
5 holding the child. I'm talking about getting
6 adequate information and reporting to the DSS so
7 they can make a reasonable --

8 THE COURT: Well, the -- the -- the lynchpin information
9 is: We can't say that this injury was the result
10 of child abuse, based on our -- our thorough -- and
11 they did a thorough -- they kept the child three
12 days -- based on a thorough -- or might've been
13 four -- thorough medical examination. We can't say
14 that this injury -- the focus is on whether the
15 child was abused, not whether the parents had risk
16 factors. We can't say this injury was caused by
17 child abuse.

18 MS. CASEY: From a medical perspective.

19 THE COURT: Well, that's the bottom line.

20 MS. CASEY: Well, Your Honor, it's not --

21 THE COURT: Somebody -- you can have all the risk
22 factors you want, but as long as nobody can say
23 that the injury is caused by child abuse, there's
24 nothing to be done.

25 MS. CASEY: I disagree with -- with Your Honor in that.

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

20 THE COURT: What -- what right --

21 MS. CASEY: -- our experts are going to talk about that.

22 THE COURT: What right does DSS -- obviously, the -- the
23 hospital cannot implement, carry out a -- a post-
24 discharge plan with respect to the custody of the
25 child. That's -- that's the -- that's the

1 providence of DSS.

2 MS. CASEY: No, sir. But they can carry out --

3 THE COURT: Listen to me.

4 MS. CASEY: Yes, sir.

5 THE COURT: What -- what -- what right would DSS have to
6 impose a plan on a child -- on a -- on the parents
7 of a child just because risk factors existed if --
8 if no one was able to say this injury is a result
9 of child abuse?

10 MS. CASEY: Well, Your Honor, they did.

11 THE COURT: No. Answer -- answer my question.

12 MS. CASEY: Okay. What right?

13 THE COURT: What -- does DSS have the statutory right to
14 -- to -- to intervene in the parent-child
15 relationship simply because these parents had every
16 risk factor you say was -- was relevant to a
17 consideration of this case --

18 MS. CASEY: I --

19 THE COURT: -- if the injury could not be attributed to
20 child abuse?

21 MS. CASEY: Well, Your Honor, I believe that the -- the
22 statute does, based on the -- the -- that the right
23 that DSS has to -- and -- and the right that they
24 have to -- if they feel, based on just the
25 preliminary findings, they can take the child if

1 they want to, so yes they do have --

2 THE COURT: They have to have a reasonable basis to do
3 that.

4 MS. CASEY: Well, they -- and I think those risk factors
5 and the injury would have been a reasonable basis
6 had they determined that it was so. I believe that
7 that could have been implemented. So, yes, they
8 do --

9 THE COURT: I'm not a family court judge, but that
10 sounds farfetched to me.

11 MS. CASEY: They do have the right to intervene. And --
12 and there are a number ways -- and I am not a
13 family law attorney, but my understanding of the
14 statute is that they can intervene and those
15 interventions are various tools that -- as a matter
16 of fact, there was -- part of the plan was that the
17 parents were to get some parenting classes, so,
18 yes, the DSS had the authority to tell these
19 parents, "You need to do more than just take this
20 child home and come back and have the reassessment
21 in a week at the hospital." And with respect to
22 the hospital, I do believe that they have the right
23 to do post-discharge planning, not with respect to
24 custody of the child.

25 THE COURT: They can't impose it.

1 MS. CASEY: Not with respect to custody of the child,
2 but with respect to treatments that -- and --

3 THE COURT: Of course.

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

1 And as a -- and -- and we have the sufficient
2 evidence and the facts to say that duty was
3 violated, and that is a question for the fact
4 finder of the jury to determine if it was violated.
5 We know there was a duty there. We believe it.
6 This is our job to --

7 THE COURT: No. We don't know there was duty. You --
8 you're telling me that -- that your position is
9 that there was a duty.

10 MS. CASEY: Yes, Your Honor. But you said in the last
11 hearing that -- you said, "I'll give you that there
12 was duty to this child while he was in the custody
13 and control in the hospital."

14 THE COURT: That is to -- to maintain -- to keep him
15 safe in the hospital. To keep him safe from injury
16 in the hospital.

17 MS. CASEY: And I believe the duty goes beyond just
18 keeping him safe in the hospital.

19 THE COURT: It was not a duty -- I did not mean -- mean
20 to imply or certainly didn't express that there was
21 a duty of the hospital to -- to -- to perform -- to
22 take action in spite of DSS's direction.

23 MS. CASEY: Well, Your Honor, if -- if -- if -- and I'm
24 sorry if I misunderstood that.

25 THE COURT: And -- and what I'm saying is: If they'd

1 done everything that they could have done in -- in
2 -- in -- in identifying risk factors and all that,
3 if DSS says release the child to the parents, they
4 have no right, let alone a duty, to hold the child.
5 And in any event, the statute that gives them a
6 super -- sort of a super right to hold the child
7 after they make a determination only gives them, I
8 think, what 20 -- 24 hours? 48 hours?

9 MR. TODD: It's 24 in South Carolina; 12 in North
10 Carolina.

11 THE COURT: 24 in South Carolina and 48 in North
12 Carolina.

13 MS. CASEY: Right.

14 THE COURT: And they exceeded that in any event.

15 MS. CASEY: Your Honor, it doesn't go to holding the
16 child. That's not the issue. The issue is the
17 appropriate -- the duty to do an appropriate
18 assessment. That was not undertaken, and as a
19 result of that, the information that was necessary
20 that -- and is supported by our expert affidavits
21 and -- and will be supported by their testimony was
22 not relayed to the appropriate person in order that
23 decisions would be made. And I believe the fact --
24 finder of fact will -- can determine and -- and a
25 reasonable juror could find that as a result of

1 that, this child was given back to the parents and
2 he was injured and it was foreseeable that that
3 would happen. And that is the reason that summary
4 judgment is not appropriate in this circumstance
5 and this case because there is a duty. I believe
6 our experts, under the -- the rules, show -- will
7 show that there was a breach of that duty, and they
8 will show what the standard of care is. And --

9 THE COURT: Now, tell me whether that duty -- whether
10 the breach of the duty -- if we assume that to be
11 true -- was the approximate cause of the -- of the
12 ultimate catastrophic injury of the child in this
13 tragic case.

14 MS. CASEY: Well, Your Honor, the approximate cause
15 issue is, yes. Yes, it was. It -- because it's
16 not only, but for, I believe, the cause -- the
17 cause, in fact, but -- but for the negligence of
18 these hospital employees and their failures to
19 perform adequate assessments that -- that
20 information was not obtained that would have
21 enabled all concerned to make a reasonable decision
22 with regard to the future safety and protection of
23 this child. And failure to do so based on the
24 injury that he presented with, it was foreseeable
25 and, but for that -- that inaction, probable that

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1 this child was going to suffer additional injury,
2 and that's exactly what happened.

3 THE COURT: I disagree with you.

4 Let me hear from the other side.

5 MR. TODD: Your Honor, the -- the order for summary
6 judgment is appropriate. The -- the plaintiff in
7 the motion for reconsideration really does not make
8 any new arguments.

9 The -- the -- the crux of the plaintiff's case
10 is that some -- for some reason, Charlotte
11 Mecklenburg Hospital should have retained custody
12 of this child for some indeterminate period of
13 time, even in the -- in light of DSS advising them
14 or instructing them to discharge the child to his
15 parents. The Charlotte Mecklenburg Hospital had no
16 right, had no duty to maintain the child or to
17 retain custody of the child. There's a statutory
18 scheme that sets forth the duties and obligations
19 surrounding removal of a child from a parent. It
20 rests squarely with DSS and the courts.

21 THE COURT: I -- let me -- I -- I do want to ask you
22 this: Is -- do you have -- have any opinion about
23 whether if -- if DSS -- if the hospital had -- had
24 -- had attributed to these parents every risk
25 factor there was -- shall we call it

1 "stereotyping?" Isn't that the proper term now? --
2 attributed to these parents every risk factor
3 possible, but, yet, could not -- but, yet, could
4 not say that the injury was a result of abuse, what
5 -- what was DSS's right, without -- without --
6 without some finding that there was -- that the --
7 that -- that the injury was most probably abuse by
8 -- by -- by the -- you know, the -- the medical
9 standard of abuse? And assuming that they
10 identified all the risk factors, what right did --
11 did DSS have to take the child away, if any?

12 MR. TODD: Well, Your Honor --

13 THE COURT: Do you know?

14 MR. TODD: -- I -- I -- I don't know. I don't know. I
15 would defer to Mr. Frawley, who represents DSS on
16 that, but --

17 THE COURT: Oh. Well, I -- all right. I want to
18 hear from him.

19 MR. TODD: Well, I don't mean to put the burden on
20 him, but you can't -- I don't think that there's
21 any court that would say because of risk factors or
22 -- or, you know, low socioeconomics, whether you
23 have a job or not, that they're going to take a
24 child away from his parents without something else.
25 In -- in this case, you know, what the plaintiffs

1 are arguing is that -- is that -- that if you -- if
2 you read their -- their motion on the -- for
3 reconsideration, is that some -- for some --
4 somehow, through somehow Charlotte Mecklenburg
5 Hospital should have done a home visit. And I'm
6 not sure of the mechanism for the hospital in -- in
7 Charlotte doing a home visit in York.

8 THE COURT: I don't know what right they have to do it.

9 MR. TODD: I don't know how they would do that.

10 THE COURT: Absent the consent of the parents.

11 MR. TODD: But -- but DSS did a home visit, and --

12 and there was a -- yeah. The DSS was continuing
13 its -- its investigation of this matter. They did
14 a home visit; they notified the sheriff. And, you
15 know, the -- the -- they were continuing to
16 investigate. The parents entered into a consent
17 order where they agreed to do certain things such
18 as parenting classes. But -- but the hospital had
19 no duty -- they had no right --

20 THE COURT: The -- the -- the parents -- and I --

21 I don't remember that. The parents did, as a
22 result of DSS's own investigation, enter an order
23 to -- to, among other things, go to parenting
24 classes -- attend --

25 MR. TODD: Where --

1 THE COURT: -- parenting classes?

2 MR. TODD: They did enter into -- when DSS -- on those

3 -- a -- (To Mr. Frawley) What is the term for

4 that?

5 MR. FRAWLEY: (To Mr. Todd) Safety plan.

6 MR. TODD: A safety plan.

7 THE COURT: A safety plan?

8 MR. TODD: That --

9 THE COURT: Okay.

10 MR. TODD: That they agreed that DSS could come in and

11 do a home visit, and they agreed to do parenting

12 classes. Now, the parenting classes hadn't

13 actually occurred at the time the child came back

14 to the hospital.

15 THE COURT: Right.

16 MR. TODD: But the parents did enter into a safety

17 plan with DSS that included DSS having the right to

18 come in and do a home visit. But -- but the --

19 really the -- the crux -- as you -- as you

20 identified, the crux of the case is -- is that the

21 hospital had no duty to maintain this child when

22 DSS has advised them to discharge the child to the

23 parents.

24 THE COURT: Now, of course, what she's saying is

25 that they would have if the hospital had done this

1 -- submitted -- given more information. What --
2 what -- what all -- what was in the report that the
3 social worker made?

4 MR. TODD: Well, the social worker, in her
5 testimony, she says, "I'm essentially a liaison
6 between the medical doctors and the DSS social
7 workers."

8 THE COURT: Uh-huh.

9 MR. TODD: And she reported the -- the findings that
10 the doctors -- you know, the medical findings to
11 DSS so DSS could make its decision.

12 THE COURT: So is it -- is it your -- is it
13 your position, then, that this social worker did
14 not occupy a position that is consistent with what
15 -- what the plaintiff's experts say her position
16 was?

17 MR. TODD: Well, I'm -- I --

18 THE COURT: You see what I'm saying?

19 MR. TODD: Well, she interviewed the parents, and
20 she talked with the doctors, and she provided the
21 information that she obtained to DSS. But the
22 ultimate decision is for DSS to make.

23 THE COURT: Well, I -- I don't disagree with that, but
24 I -- but I -- I guess what I'm saying is: Did she
25 occupy the role that they say she occupied, or was

1 she more -- you say she says she's a liaison.

2 MR. TODD: To --

3 THE COURT: That's a whole lot different than what --

4 than -- than what they're saying is the role

5 that -- that the social worker occupies.,

6 MR. TODD: What they're saying is that she's the one

7 who makes the decision, not DSS.

8 THE COURT: Well --

9 MR. TODD: And she's not the decision maker --

10 THE COURT: No. I don't think --

11 MR. TODD: -- on the --

12 THE COURT: -- think that.

13 MR. TODD: -- discharge of the child.

14 THE COURT: I -- I just think they imposed more --

15 more obligation upon her than your description of

16 her -- of her job description is, and I'm -- I'm

17 saying, do you -- did -- I'm asking you: Did --

18 did -- did -- did the social worker occupy a

19 position with a job description consistent with

20 what they say it ought to have been?

21 MR. TODD: No, sir.

22 THE COURT: Okay. All right. Thank you.

23 Mr. Frawley, give me your full name, please,

24 sir?

25 MR. FRAWLEY: My name is Patrick Frawley, F-r-a-w-l-e-y.

Hearing

1 THE COURT: Thank you very much. I can't remember
2 if you -- I don't think you were here the last
3 time, were you?

4 MR. FRAWLEY: I was. I was.

5 THE COURT: You were?

6 MR. FRAWLEY: Yes, sir.

7 THE COURT: I'm sorry. Well, I -- that's my fault.

8 MR. FRAWLEY: I was smiling and nodding my head as Mr.
9 -- Mr. --

10 THE COURT: You didn't get a chance to talk?

11 MR. FRAWLEY: No, sir.

12 THE COURT: All right. Mr. Frawley, tell -- tell me
13 about the -- the DSS paradigm, all right?

14 MR. FRAWLEY: Okay. Your Honor, when -- when we
15 get called into a -- to a -- to a case -- when
16 there's an intake, we have -- depending on the
17 severity of the case, we have a certain time frame
18 within which to -- to -- to respond. And in this
19 case, we did respond quickly. And I -- I don't --
20 I wasn't prepared to argue today, so my -- my
21 recollection is the call-in was December 6th. And
22 we responded; we had an on-call caseworker who did
23 respond, went to Charlotte, did see the parents,
24 did talk to hospital personnel, did -- was able to
25 make her initial assessment. And then the next day

1 -- because she was an on-call caseworker -- they
2 staffed the case, and the case was transferred to
3 CPS or Child Protective Services case workers, who
4 -- who typically handle those cases. She was on-
5 call that night. She responded, got the initial
6 information, and then it was transferred the next
7 day.

8 THE COURT: All right.

9 MR. FRAWLEY: Now, I think the child was released the
10 8th or the 9th. I don't remember. Within three
11 days/four days possibly.

12 THE COURT: Three or four days.

13 MR. FRAWLEY: During that period of time, we had a --
14 a case worker, Ms. Devandra Hill, who was -- who
15 was doing some work on it. We also had a
16 supervisor, whose name escapes me now, but -- but
17 she was our supervisor who worked with Ms. Hill and
18 was in that -- that initial staffing. That
19 supervisor had direct contact with the hospital
20 social worker, repeatedly trying to find out was it
21 -- and you -- Your Honor's probably seen the term
22 "NAT," non-accidental trauma -- was it something
23 that looks like abuse, or was it possibly
24 accidental trauma?

25 And the -- the social worker she was dealing

1 with, pretty much by the telephone, was a social
2 worker with whom she'd dealt several times before
3 with --

4 THE COURT: Is all this --

5 MR. FRAWLEY: -- this hospital.

6 THE COURT: -- in discovery, by the way --

7 MR. FRAWLEY: That --

8 THE COURT: -- already?

9 MR. FRAWLEY: Yes.

10 THE COURT: Okay.

11 MR. FRAWLEY: Yes. That -- and that's in -- that's in
12 the DSS dictation that was provided.

13 THE COURT: All right. All right. I haven't read all
14 of it.

15 MR. FRAWLEY: Yes, sir. Well, there -- it --

16 THE COURT: It's about 8 inches thick.

17 MR. FRAWLEY: It's a bunch to read. But -- but she
18 -- she did have several conversations and telephone
19 conversations with the social worker for purpose of
20 finding out: Did the doctor feel this was NAT?
21 Because that -- that was going to be one of the
22 pivotal issues: Was the etiology of the injury
23 possible abuse? And -- and we were never able to
24 get a -- a clear -- clear read on that.

25 Now, we also got information from the social

1 worker in --

2 THE COURT: What you got --

3 MR. FRAWLEY: -- those calls --

4 THE COURT: -- was a -- was an opinion that said,

5 "We can't say," right?

6 MR. FRAWLEY: That -- yes, sir. Yes, sir. What --

7 what they were saying in -- in -- in the -- the --

8 the phone call discussions in there or the --

9 the -- the DSS dictation of those phone calls from

10 our supervisor, based on the phone calls with the

11 social worker, was that she was going to talk to

12 the doctor -- with the doctor who, I think, has

13 been deposed in this case. She was going to talk,

14 and -- and that doctor was going to let us know,

15 and -- and we never got a clear read --

16 THE COURT: You say "she"? The social --

17 MR. FRAWLEY: The --

18 THE COURT: -- worker --

19 MR. FRAWLEY: The --

20 THE COURT: -- was going to talk --

21 MR. FRAWLEY: Well, the social worker was going to

22 talk to the doctor and then be able to relay that

23 information back to us. And there was also a phone

24 call, as I recall, with the doctor herself, and the

25 doctor could never say clearly whether it was non-

Hearing

1 accidental trauma or accidental trauma. In other
2 words, we never had a clear read that it was
3 accidental. Now, as far as the --

4 THE COURT: Is there -- is there a threshold burden of
5 -- of proof, if you -- if I --

6 MR. FRAWLEY: Well --

7 THE COURT: -- can use that term --

8 MR. FRAWLEY: Well, the -- the --

9 THE COURT: -- that -- that DSS operates under for
10 that purpose?

11 MR. FRAWLEY: Yes, sir. The burden we have to look
12 at -- if we go in there and our -- our caseworker
13 and our supervisor -- because it's not one person's
14 decision; they staff it. The -- the burden is that
15 if -- if we believe that there is a -- a threat of
16 possible abuse there, we'll staff it and then they
17 can, you know -- people use the term --

18 THE COURT: So --

19 MR. FRAWLEY: -- we, you know --

20 THE COURT: -- based on the information --

21 MR. FRAWLEY: -- we "take the child."

22 THE COURT: -- they had, they believed there was a
23 threat of possible abuse?

24 MR. FRAWLEY: Well, based on the information they had,
25 they didn't know. We -- we knew we had these risk

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1 factors.

2 THE COURT: Yes sir.

3 MR. FRAWLEY: But, Your -- Your Honor, the term you used
4 was -- I forget the term you used, but "profiling."
5 We -- we can't --

6 THE COURT: "Profiling" is what I should've used.

7 MR. FRAWLEY: Yes, sir.

8 THE COURT: Yes.

9 MR. FRAWLEY: If -- if -- if we removed every child
10 whose parents were young and poor and -- and -- and
11 these were --

12 THE COURT: Single.

13 MR. FRAWLEY: -- these were Caucasians or single,
14 without jobs, you know, with -- with stresses,
15 there'd be a lot more children removed. There --
16 there's a threshold showing we have to have.

17 Now, if we -- if we feel that and we want to
18 remove that child, the burden for us is that it --
19 it's almost a preponderance of the evidence. There
20 has to be more likely than not that there was
21 abuse.

22 THE COURT: All right.

23 MR. FRAWLEY: And -- and before we get to that point,
24 there has to be some indication that there was
25 abuse, and then we'll look at the risk factors.

Hearing

1 Now, I -- I disagree with Ms. Casey that --

2 THE COURT: So would that -- would that, thus, then

3 require a medical finding that there was abuse in

4 -- in a -- in a -- in a -- in a -- in a case where

5 the only evidence was medical findings?

6 MR. FRAWLEY: Yes, sir. Yes, sir.

7 THE COURT: Okay.

8 MR. FRAWLEY: At least something definitive from them

9 saying it -- it -- it looks like abuse. Now, the

10 -- the --

11 THE COURT: Okay.

12 MR. FRAWLEY: -- the subdural hematomas can -- can occur

13 accidentally. Not -- not just -- not just --

14 THE COURT: Right.

15 MR. FRAWLEY: -- by -- by non-accidental trauma. And --

16 and -- and that was the pivotal issue our people

17 were looking for. Do we have somebody medically

18 who can tell us, because we're not doctors, to --

19 to a medical degree of -- of certainty, that it's

20 more probable than not that -- that this was non-

21 accidental trauma? We never got that. But as far

22 as the risk factors, that information was conveyed

23 to us, as well. Now, we have a -- I mean, we --

24 THE COURT: By the hospital?

25 MR. FRAWLEY: -- can recognize -- by the hospital, by

1 -- by the social worker, and by when our caseworker
2 went there, she was able to pick that up when --
3 when she -- she got there. But -- but we also had
4 other information about these being young parents
5 and possibly needing supervision. In fact, when we
6 first got to the hospital, we were under the
7 impression that -- that -- that they thought we
8 were the sitters, that we were there to relieve the
9 sitters. So it -- it -- it wasn't an issue that
10 had risen to that level, yet, but if we feel we're
11 going to remove it and -- and they don't agree to a
12 safety plan -- you heard the term "safety plan"?

13 THE COURT: Yes sir.

14 MR. FRAWLEY: -- we go to them and we say, "Here's what
15 we would like to do." If -- if we're going to
16 remove the children, you know, we're going to put
17 them -- we have to look for relative placement
18 first, have a family meeting. There's a panoply of
19 things we have to do, but we go to the parents and
20 say, "Here's the plan we'd like to propose to you.
21 Do you voluntarily agree with this?" If they do
22 and they sign it, then we -- we activate that plan.
23 If they say, "No. We're not going to do that. I
24 don't want you taking my children out," then we
25 have an obligation to go to family court and -- and

1 then we have to present our case and we have to --
2 to convince a family court judge that it's more
3 likely than not that this occurred, for --

4 THE COURT: So, was the --

5 MR. FRAWLEY: -- the judge to -- to rubberstamp our --
6 our removal.

7 THE COURT: So, was the presentation of the safety plan
8 a precursor to taking the child if they did not
9 agree to it?

10 MR. FRAWLEY: If -- no, sir. If we wanted to remove the
11 child, we could've stuck that in there, which we
12 did not do.

13 THE COURT: Right.

14 MR. FRAWLEY: But -- but if we wanted to remove the
15 child and we said, "Remove the child. Place him
16 with your grandmother or with your mother, Ms.
17 Williams" --

18 THE COURT: Right.

19 MR. FRAWLEY: -- and they said, "No. We don't want to
20 do that," then, if we felt we needed, we -- we
21 could either say, "Well, fine. We're going to
22 leave it where it is," if we didn't feel we had the
23 evidence. If we felt we did have the evidence, we
24 would've had law enforcement come in. DSS can't
25 remove them; it's got to be law enforcement,

1 with -- with our -- with our direction. And then
2 we would've had to go to a family court judge and
3 convince a family court judge that -- that it's
4 more likely than not that there was abuse at that
5 point. And there'd be kind of a -- a short
6 hearing --

7 THE COURT: So -- so, the safety plan is not -- the
8 safety plan is just what it is? That's -- that's
9 as far as you go presenting a safety plan that does
10 not include removal?

11 MR. FRAWLEY: It can include removal.

12 THE COURT: Well, I know it can, but what I'm saying is:
13 In this instance, is it DSS's position that the
14 safety plan went as far as the -- as the evidence
15 permitted them to go at that point?

16 MR. FRAWLEY: Yes, sir.

17 THE COURT: All right. Which it did not include
18 removal?

19 MR. FRAWLEY: We did not include removal. And with
20 regard to the investigation, statutorily we have 45
21 days --

22 THE COURT: Yes, sir.

23 MR. FRAWLEY: -- from the intake to complete our
24 investigation. If we need additional time, we can
25 ask for another 15 days, during which time there

1 are staffings and certain things we have to do,
2 which we'll discuss on another day. But -- but
3 that -- that was done, and then the second injury
4 occurred within that initial 45 days.

5 THE COURT: Okay. But the safety -- the safety plan
6 predated the second injury, didn't it or did it
7 not?

8 MR. FRAWLEY: Yes. Oh, there are several safety plans.
9 So, I mean --

10 THE COURT: But, I mean --

11 MR. FRAWLEY: -- they -- they kept updating the safety
12 plans.

13 THE COURT: Okay. So -- oh. All right.

14 MR. FRAWLEY: We had a safety plan that first night.
15 There was a safety plan entered that first night
16 which basically said, "You will not remove the
17 child from the hospital. You will do what the
18 hospital tells you to do with regard to treatment
19 of the child. You will comply with whatever" --

20 THE COURT: All right.

21 MR. FRAWLEY: -- "they say."

22 THE COURT: All right.

23 MR. FRAWLEY: But we --

24 THE COURT: And then there was --

25 MR. FRAWLEY: -- we did not have anything in there about

1 removing the child.

2 THE COURT: But then -- then -- then after removal --
3 after discharge but before the -- the second
4 injury, there was a safety plan in place that
5 did -- dealt with after discharge?

6 MR. FRAWLEY: Yes. In -- in fact, it was updated
7 several --

8 THE COURT: All right.

9 MR. FRAWLEY: -- several times.

10 THE COURT: All right.

11 MR. FRAWLEY: But never -- never including removal.

12 THE COURT: All right.

13 MR. FRAWLEY: And as far as parenting classes, that's
14 typically considered treatment. We have assessment
15 up until the point that we determine it's indicated
16 or they agree with it, and then from that point,
17 then it transfers to the treatment plan, which --
18 which would be -- could be parenting classes, could
19 be any number of things. We were still in the
20 assessment period.

21 THE COURT: All right. Let me think.

22 Now, let me ask you the hardest question --

23 MR. FRAWLEY: Yes, sir.

24 THE COURT: -- I guess. Assuming the -- the -- the --
25 the numerous risks factors, you know, youth,

1 single, unemployed, whatever else there may be --
2 assuming you identify those but can't connect those
3 with an injury that is -- say if the injury is --
4 is probable abuse, do you nevertheless have the
5 right to take any action --

6 MR. FRAWLEY: We have the right --

7 THE COURT: -- absent a connection between the injury --
8 or absent a determination that the injury was
9 probable abuse?

10 MR. FRAWLEY: We have the right to take the action, but
11 we have to pass muster, either get a safety plan
12 where the parents say, "Sounds good to us. Go
13 ahead and do it," or we have to pass muster with a
14 -- with a family court judge and prove to him that
15 based on what we've got, the -- the risk factors
16 and somebody with -- with -- with more medical
17 weight than we've got saying it's -- it's an injury
18 that is caused by non-accidental
19 trauma.

20 THE COURT: That's what I'm saying.

21 MR. FRAWLEY: Yes, sir.

22 THE COURT: You -- is -- is -- is everything after that
23 positive necessarily on a finding that -- that
24 there was non-accidental trauma?

25 MR. FRAWLEY: Yes, sir. That's why that --

1 THE COURT: All right.

2 MR. FRAWLEY: -- was a pivotal issue for us.

3 THE COURT: All right.

4 MR. FRAWLEY: But we were aware of the risk factors and
5 that information was discussed with us by the
6 hospital.

7 THE COURT: Thank you.

8 Ms. Casey anything else, briefly?

9 MS. CASEY: Well, yes, Your Honor. Briefly. The -- the
10 hospital did tell the DSS that they felt that they
11 could not find what the cause of the -- of the --
12 the hemorrhages were, but I think the literatures
13 replete that children that are three years old
14 rarely have an accidental injury such as this. So
15 that's one of the reasons that the -- the index of
16 suspicion was so high. There were identified
17 potentially poor parenting skills and some
18 supervisory issues, but this was never gone into in
19 depth to have an interview in the hospital by the
20 social worker with respect to that some of these
21 risk factors -- and it's not just the risk factors,
22 and it's not profiling.

23 THE COURT: I -- I thought Mr. Frawley said that -- that
24 -- that as a result of what the hospital did, that
25 the DSS person actually directly interviewed the

1 parents?

2 MS. CASEY: Well, that interview was just the one time
3 in the hospital, and --

4 THE COURT: Well, no. But they did it.

5 MS. CASEY: -- it was very briefly. It was very
6 briefly, and there was no information to gain --

7 THE COURT: What is "very briefly"?

8 MS. CASEY: She was there probably for about 45 minutes.

9 THE COURT: Oh.

10 MS. CASEY: So, that was not a long -- and, then, she
11 was in the process of talking to other individuals,
12 too. So this was not a -- an in depth interview
13 that a social worker would have been -- and would
14 have been trained to do. This was an on-call
15 individual who was not a trained master-degreed
16 social worker that could have gone and done an in
17 depth interview with the parents and discussed not
18 only the risk factors, but have -- could have gone
19 into further detail about the facts and
20 circumstances surrounding the discovery of this
21 child being unresponsive, what was going on, things
22 of that nature. So there was a -- a very -- there
23 was a -- just a lack of information that was
24 obtained during that period of time when the --
25 they were in the best position to do that.

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

1 proper at this time.

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

23 (Whereupon,, the proceeding in the
24 above-entitled matter was adjourned
25 at 10:23 a.m.)

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

vs.

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

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

**MOTION AND ORDER INFORMATION FORM
AND COVER SHEET**

<u>name, SC Bar no. and address of plaintiff's attorney:</u> S. Randall Hood, Esquire McGowan Hood & Felder, LLC 1539 Health Care Drive Rock Hill, SC 29732 e-mail: other:		<u>name, SC Bar no. and address of defendant's attorney</u> Monteith P. Todd Sowell Gray Stepp & Laffitte, LLC 1310 Gadsden Street, P.O. Box 11449 Columbia, SC 29211 (803) 929-1400 e-mail: mtodd@sowellgray.com other:	
☒ MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III) ☐ FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III) ☐ PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)			
SECTION I: Hearing Information Nature of Motion: Motion for Summary Judgment Estimated Time Needed: 20 minutes Court Reporter Needed: YES ☒ NO ☐			
SECTION II: Motion Type ☒ Written motion attached ☐ Form Motion: I hereby move for relief or action by the court as set forth in the attached proposed order. _____ Signature of Attorney for ☐ Plaintiff ☐ Defendant Date Submitted			
SECTION III: Motion Fee ☒ PAID – AMOUNT: \$25.00 (check reason) ☐ EXEMPT: ☐ Rule to Show Cause in Child or Spousal Support ☐ Domestic Abuse or Abuse and Neglect ☐ Indigent Status ☐ State Agency v. Indigent Party ☐ Sexually Violent Predator Act ☐ Post Conviction Relief ☐ Motion for Stay in Bankruptcy ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP) ☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions Name of Court Reporter: _____ ☐ Other:			
JUDGE'S SECTION ☐ Motion Fee to be paid upon filing of the attached order. ☐ Other:		_____ JUDGE CODE: _____ Date: _____	
CLERK'S VERIFICATION DATE FILED Collected by: _____ (print name) ☐ MOTION FEE COLLECTED: _____ ☐ CONTESTED – AMOUNT DUE: _____			

SCCA/233 (1/2003)

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STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

Elizabeth Hope Rainey, as the)
Appointed Guardian ad Litem to)
Owen C. [REDACTED] a minor)

Civil Action No. 11-CP-46-4508

Plaintiff,)

v.)

**NOTICE OF MOTION AND MOTION
FOR SUMMARY JUDGMENT**

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

Defendants.)

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

FACTUAL SUMMARY

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

BASIS FOR DEFENDANT'S MOTION

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

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

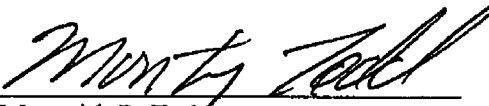
raised a suspicion that Owen C. [REDACTED] had been a victim of non-accidental trauma. The Charlotte-Mecklenburg Hospital Authority contacted the South Carolina Department of Social Services and notified it of Owen's condition and of its suspicion that Owen had been a victim of non-accidental trauma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

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

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

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

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

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Feb 26, 2013

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

Elizabeth Hope Rainey, as the)
Appointed Guardian ad Litem to)
Owen C [REDACTED] a minor)

Civil Action No. 11-CP-46-4508

Plaintiff,)

v.)

MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT

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

Defendants.)

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

FACTUAL SUMMARY

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

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

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

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

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

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

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

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

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

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

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

A physician, nurse, . . . or any other . . . health professional . . . must report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected as defined in Section 63-7-20.

. . .

(D) Reports of child abuse or neglect may be made orally by telephone or otherwise to the county department of social services or to a law enforcement agency in the county where the child resides or is found.

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

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

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

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

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

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

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

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

Hospital informed DSS it could neither rule in nor rule out non-accidental trauma with Owen C. DSS, which was conducting its own investigation, advised Levine Children's Hospital to discharge Owen to his parents. The decision on whether or not Owen should be discharged to his parents was a decision for DSS, not for Levine Children's Hospital.

Under South Carolina law, any right of a doctor or hospital to retain a child suspected of being abused is limited to 24 hours. See South Carolina Code Ann. § 63-7-750. Even then, the hospital only has the right to refuse discharging the child to his custodian until a law enforcement official can arrive to determine whether the officer should take emergency protective custody of the child. After that 24 hour time period, a doctor has no more right nor duty to retain a child than does a total stranger, which is to say they have no right at all. Even then, the only entity allowed to retain custody over a child in derogation of a parent's rights is the Department of Social Services, and only if the Department of Social Services meets the statutory requirements to do so.

This Defendant is Immune from Liability for the Plaintiff's Claims

Further, this defendant is immune from liability under South Carolina section 63-7-390. This statute provides:

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

S.C. Code Ann. §63-7-390.

Under this statute, anyone who participates, or takes part in, any DSS proceeding is immune from civil liability. The only way in which a person or entity is not immune from his reporting or participation under §63-7-310 is if he acts in bad faith. The South Carolina Supreme Court has defined bad faith as follows:

The opposite of good faith, generally implying or involving actual or constructive fraud, or a design to deceive or mislead another, or a neglect or refusal to [fulfill] some duty or some contractual obligation, not prompted by an honest mistake as to one's rights or duties, but by some interested or sinister motive.

Estate of Carr ex rel. Bolton v. Circle S Enterprises, Inc., 379 S.C. 31, 664 S.E.2d 83 (Ct. App. 2008) quoting State v. Griffin, et al., 100 S.C. 331, 84 S.E. 876 (1915). See also Hoskins v. Aetna Life Ins. Co., 452 N.E.2d 1315 (Ohio 1983) ("A lack of good faith is the equivalent of bad faith, and bad faith . . . embraces more than bad judgment or negligence. It imports a dishonest purpose, moral obliquity, conscious wrongdoing, breach of a known duty through some ulterior motive or ill will partaking of the nature of fraud.") The burden to establish bad faith is on the plaintiff, as good faith is presumed by statute.

In this case, Levine Children's Hospital reported to DSS that Owen might have been a victim of child abuse. Levine Children's Hospital participated and cooperated with DSS in its investigation. There is no allegation in the plaintiff's Complaint nor is there any proof that this defendant acted with any fraud or failed to fulfill some duty or obligation because it had its own interested or sinister motive. Rather, the only evidence is that this defendant reported that Owen may have been a victim of child abuse and then participated briefly with DSS in its investigation of the matter. Thus, not only can the plaintiff not show that this defendant breached any duty of care to the plaintiff, this defendant is immune from liability under S.C. Code Ann. §63-7-390.

This motion is supported by this memorandum, the pleadings, depositions of Dr. Cheryl Courtlandt (the attending pediatrician for Owen Carduff at Levine Children's Hospital), Laura Newmark (a social worker at Levine Children's Hospital), Krista Hinnant and Divondra Hall (social workers at DSS), Kayla Lythgoe (plaintiff's mother), Charlotte Williams (plaintiff's maternal grandmother), and Larry Williams (plaintiff's maternal step grandfather), and the exhibits to those depositions.

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April 17, 2013

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
	)	
Elizabeth Hope Rainey, as the	)	Civil Action No.: 2011-CP-46-4508
Appointed Guardian ad Litem to	)	
Owen C [REDACTED] a minor	)	
	)	
Plaintiff,	)	
	)	PLAINTIFF'S MEMORANDUM
v.	)	OF LAW IN OPPOSITION TO
	)	DEFENDANT CHARLOTTE-
Charlotte-Mecklenburg Hospital	)	MECKLENBERG HOSPITAL
Authority d/b/a Carolinas Medical	)	AUTHORITY'S MOTION FOR
Center; South Carolina Department of	)	SUMMARY JUDGMENT
Social Services, and Bruce Bryant, as	)	
the Constitutional Office of the Sheriff	)	
of York County, the York County	)	
Sheriff's Department, and York County,	)	
	)	
Defendants,	)	
	)	

Plaintiff Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to Owen C [REDACTED] a minor, through her attorneys, respectfully submits this Memorandum of Law in Opposition to Defendant Charlotte-Mecklenburg Hospital Authority's ("CMC") Motion for Summary Judgment.

FACTS

Three-month old Owen [REDACTED] C [REDACTED] was alone with his father Michael on December 4, 2009, when Owen "got real stiff," turned red, and appeared to be "straining." Michael and Owen's mother Kayla Lythgoe took the infant to the emergency room at Piedmont Medical Center ("PMC"). After triage and an examination, Owen was transferred to Carolinas Medical Center's Levine Children's Hospital ("LCH") in Charlotte, North Carolina. Owen was admitted to LCH during the morning hours of December 5th and medical tests were performed to

determine the cause of his physiological symptoms. A CT scan revealed a subdural hematoma, i.e. bleeding on his brain.

LCH also activated procedures for care of a suspected child abuse victim by notifying the York County division of the South Carolina Department of Social Services (“DSS”) and utilizing a “CHS Suspected Abuse and Neglect” form. LCH policy also required the hospital to consult its on-staff medical social workers. According to CMC policy, the social stability of a patient’s home environment is a distinct and independent factor for CMC personnel to consider during a patient’s hospitalization and especially at the time of the patient’s anticipated discharge. During Owen’s hospitalization from December 5-8, 2009, his family was contacted by CMC social workers Katie Harrison and Laura Newmark. CMC officials were concerned about suspected abuse and posted a sitter in Owen’s hospital room. During that four day period, Owen’s grandmother told a CMC nurse that Owen suffered a bruise just weeks earlier while in Michael’s care and Michael had no explanation for the injury. After the subdural hematoma was diagnosed, neither parent could explain how the injury happened. Ms. Harrison and Ms. Newmark took very brief notes of their conversations with Michael, Kayla, and a couple other family members.

When a neurosurgeon examined Owen the night before his discharge, Owen was **medically** cleared for discharge but only “under supervision.” The following day, Owen was discharged to his parents. The required safety plan was not attached to Owen’s chart at the time of his discharge. A few weeks later, Michael was again left alone with Owen. As he had many times before, Michael “got frustrated with” Owen to the point of being “angry” with the infant. When Michael left his house to take Owen for a car ride, Michael “shook” Owen in an effort to get Owen to quiet down. Michael later admitted to police officers he dropped Owen down a set

of concrete stairs that same night while Owen was in his car seat. Hours later, Michael and Kayla noticed Owen was in distress. Instead of crying, Owen was “moaning” and “twitching all over.”

Owen was again rushed to PMC and later transferred to LCH where he was diagnosed with a new subdural hematoma, retinal hemorrhaging, and persistent seizures. Doctors determined Owen suffered an anoxic brain injury and had a very poor prognosis. He was unable to either see or hear. Owen received morphine for his pain and was eventually placed in hospice care. After a period of hospice care, Owen’s medical outlook began to improve. He was released from hospice but has suffered serious, permanent injuries. Michael, Carduff, the father of Owen Carduff, plead guilty to child abuse and is currently in prison.

SUMMARY JUDGMENT STANDARD

To grant a motion for summary judgment, the court must find that "there is no genuine issue as to any material fact." Rule 56(c), SCRCp. The judge is not to weigh the evidence but rather to determine if there is a genuine issue for trial. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). For claims where the preponderance of evidence burden applies, “the non-moving party is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment.” Hancock v. Mid-South Mgmt. Co., 381 S.C. 326, 330, 673 S.E.2d 801, 803 (2009).

In determining whether any triable issues of fact exist, the evidence and all reasonable inferences must be viewed in the light most favorable to the party opposing summary judgment. Summer v. Carpenter, 328 S.C. 36, 492 S.E.2d 55 (1997); Pye v. Aycock, 325 S.C. 426, 480 S.E. 2d 455 (Ct. App. 1997). Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law. Brockbank v. Best Capital Corp., 341 S.C. 372, 534 SE 2d 688 (2000); Moriarity v. Garden Sanctuary Church of God, 534

S.C. 150, 511 S.E.2d 699 (Ct. App.1999). “Because it is a drastic remedy, summary judgment should be cautiously invoked so no person will be improperly deprived of a trial of the disputed factual issues.” Carolina Alliance for Fair Employment v. S.C. Dep’t of Labor, Licensing & Regulation, 337 S.C. 476, 523 S.E.2d 795 (Ct. App. 1999).

CHOICE OF LAWS

Plaintiff’s claim against CMC is governed by South Carolina substantive law. South Carolina’s general rule governing the choice of laws is the long-standing *lex loci delicti* rule. Nash v. Tindall Corp., 375 S.C. 36, 650 S.E.2d 81 (Ct. App. 2007). This Latin term translates to “[t]he law of the place where the tort or other wrong was committed.” Black’s Law Dictionary (9th ed. 2009). South Carolina courts define the term with a bit more precision holding that the term means “the law of the state in which **the injury** occurred.” Nash, 375 S.C. at 39, 650 S.E.2d at 83 (quoting Boone v. Boone, 345 S.C. 8, 13, 546 S.E.2d 191, 193 (2001))(emphasis added).¹ As discussed in more detail below, South Carolina courts’ use of “injury” instead of “tort” or “wrong” helps to alleviate some of the difficulties presented in cases where the state of alleged wrongdoing differs from the state where the negative consequences of that wrongdoing are experienced.

South Carolina’s version of the *lex loci delicti* rule has been applied in a variety of factual scenarios. For example, in a South Carolina claim by a South Carolina resident regarding a car accident occurring in North Carolina on a trip between South Carolina and New York, North Carolina substantive law applied as North Carolina was the state where the injury occurred. See Bannister v. Hertz Corp., 316 S.C. 513, 450 S.E.2d 629 (Ct. App. 1994). In Dawkins v. State, 306 S.C. 391, 412 S.E.2d 407 (1991), Georgia residents sued the state of South Carolina after an

¹ South Carolina does recognize one exception to the *lex loci delicti* rule. This “public policy exception” provides that “the Court will not apply foreign law if it violates the public policy of South Carolina.” Nash, 375 S.C. at 41, 650 S.E.2d at 83.

escaped South Carolina Department of Corrections (“SCDC”) inmate robbed their home. The Dawkins plaintiffs alleged SCDC failed to properly restrain the inmate and the plaintiffs suffered injuries as a result. Even though the alleged wrongdoing (i.e. SCDC’s failure to monitor the inmate) occurred in South Carolina, the court held that Georgia substantive law applied as Georgia was the state where the “injury” (i.e. the plaintiffs’ physical/emotional injuries) occurred. Dawkins, 306 S.C. at 392, 412 S.E.2d at 408.

One of the most detailed discussions of South Carolina’s lex loci delicti rule comes from Lister v. NationsBank of Delaware, N.A., 329 S.C. 133, 494 S.E.2d 449 (Ct. App. 1997). In Lister, the defendant fraudulently applied a charge to the plaintiff’s credit card while the plaintiff was on vacation. The plaintiff was a South Carolina resident on vacation in Aruba when the fraudulent charge was imposed. The Court of Appeals held that South Carolina rather than Aruban law applied to the plaintiff’s breach of contract accompanied by a fraudulent act claim. The injury was damage to the plaintiff’s credit rating and this injury was experienced in South Carolina. For fraud or misrepresentation claims, the place of injury “is not where the misrepresentations were made but where the plaintiff, as a result of the misrepresentation, suffered a loss. Lister, 329 S.C. at 143, 494 S.E.2d at 455.

In this case, Plaintiff’s claim against CMC is governed by South Carolina law as South Carolina is the state in which the injury occurred. In the Complaint, Plaintiff alleges CMC “fail[ed] to adequately consider or determine whether Owen Carduff could be safely discharged” to his parents, “fail[ed] to adequately recognize or adequately consider” Owen’s previous injuries at his father’s hands, and “fail[ed] to implement...adequate additional assessment[s]” of Owen’s discharge to ensure he was released to a safe environment. Compl. ¶ 35(a)-(c). The Complaint also alleges that “[i]t does not appear that the CMC social worker...did anything to

ensure Owen Carduff's safety" after his initial discharge from CMC. Compl. ¶ 25. After Owen's discharge from CMC, "it appears Owen Carduff was beat [sic] mercilessly and put into a coma by the person who caused his first hospitalization in December 2009, Michael Carduff." Compl. ¶ 26. As a proximate cause of CMC's misconduct, Owen suffered "severe debilitating injuries which resulted in brain damage, blindness and catastrophic injuries." Compl. ¶ 36.

This is clearly a case where the place of wrongdoing and the place of experiencing the effects of wrongdoing are in different states. CMC's failure to investigate Owen Carduff's family history prior to his discharge and failure to ensure Owen was discharged to a safe environment occurred at CMC in Charlotte, North Carolina. However, the negative effects of that misconduct, i.e. the beating Owen Carduff received at the hands of his father, and the permanent disabilities Owen must now bear for the rest of his life, have been experienced in South Carolina. CMC's conduct did not constitute the tort of negligence until Owen suffered damages. Owen did not suffer damages until he was abused by his father at the family's Rock Hill, South Carolina home. Under South Carolina's *lex loci delicti* rule, South Carolina is clearly the place of the injury and South Carolina substantive law applies.

ARGUMENT

1. CMC is not entitled to summary judgment on Plaintiff's negligence claim.

a. CMC owed Owen C [REDACTED] a duty of reasonable care.

Negligence is a "breach of a duty of care owed to the plaintiff by the defendant." Savannah Bank, N.A. v. Stalliard, 400 S.C. 246, 734 S.E.2d 161 (2012). Duty is defined as "the obligation to conform to a particular standard of conduct toward another." Nelson v. Piggly Wiggly Central, Inc., 390 S.C. 382, 701 S.E.2d 776 (Ct. App. 2010). A duty or the "obligation" to which the Nelson court referred may arise from a number of different sources. A legal duty "may be created by statute, a contractual relationship, status, property interest, or some other

special circumstance.” Madison v. Babcock Ctr., Inc., 371 S.C. 123, 136, 638 S.E.2d 650 (2006). A duty may also arise by reason of the “relationship” between plaintiff and defendant. Hubbard v. Taylor, 339 S.C. 582, 589, 529 S.E.2d 549, 552 (Ct. App. 2000). Legal duties are certainly not limited to those imposed by explicit statutory enactment. See Burnett v. Family Kingdom, Inc., 387 S.C. 183, 189, 691 S.E.2d 170, 174 (Ct. App. 2010)(noting affirmative duty may be created by a statute “among other things”). A negligence claim may be based on “the common law duty to exercise reasonable care.” Richland County v. Carolina Chloride, Inc., 382 S.C. 634, 647, 677 S.E.2d 892, 899 (Ct. App. 2008). The common law duty of reasonable care applies to hospitals. see Osborne v. Adams, 346 S.C. 4, 7-8, 550 S.E.2d 319, 321 (2001)(hospital has non-delegable duty of care to patients looking to hospital as institution for care/treatment); Bain v. Self Mem'l Hosp., 281 S.C. 138, 141, 314 S.E.2d 603, 605 (Ct. App. 1984)(noting hospital owed to patient “duty of exercising reasonable care”); Sloan v. Edgewood Sanatorium, 225 S.C. 1, 80 S.E.2d 348 (1954)(noting hospital “owes a duty to safeguard and protect the patient from any known possibility of self-harm or reasonably apprehended danger”).

At its core, a duty arises from “the relationship between the alleged tortfeasor and the injured party.” Huggins v. Citibank, N.A., 355 S.C. 329, 585 S.E.2d 275 (2003). When considering whether a duty is created by means of the parties’ relationship, the courts examines the relative power and capacities of the parties. For example, a duty is more likely to be found where the plaintiff stands in an especially vulnerable position relative to the defendant. See Regions Bank v. Schmauch, 354 S.C. 648, 670, 582 S.E.2d 432, 443 (Ct. App. 2003)(considering plaintiff’s claim that she was “particularly vulnerable in th[e] situation”). Owen C. [REDACTED] a three-month old infant, is the embodiment of vulnerable individual. He was unable to defend himself from his father’s abuse and unable to verbalize the danger posed by his

home environment to CMC social workers. At the time of his admission and for the entire period of his hospitalization, Owen C. [REDACTED] looked to CMC's medical personnel and social workers to provide reasonable medical and social worker services. The relationship between CMC and Owen C. [REDACTED] created a duty of reasonable care on CMC personnel.²

Even if CMC owed Owen no general duty of care, the hospital certainly owed a duty of reasonable care once it chose to begin providing medical and social services. A person having no affirmative duty to provide services to another may still face liability related to such services if the person voluntarily undertook a responsibility and performed that responsibility with less than reasonable care. In other words, "One who assumes to act, even though under no obligation to do so, may become subject to the duty to act with due care." Cooke v. Allstate Mgmt. Corp., 741 F. Supp. 1205, 1209-10 (D.S.C. 1990) (quoting Crowley v. Spivey, 285 S.C. 397, 406, 329 S.E.2d 774, 780 (Ct. App. 1985)). This legal principle is codified in Restatement (Second) of Torts § 323, a section that South Carolina courts have repeatedly cited and applied. The section states as follows:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

- (a) his failure to exercise such care increases the risk of such harm, or
- (b) the harm is suffered because of the other's reliance upon the undertaking.

South Carolina also applies Restatement (Second) of Torts § 324. See Madison, 371 S.C. at 137, 638 S.E.2d at 657. This section provides:

² While the existence of a duty is a legal issue, whether the circumstances of a case give rise to a special relationship between the parties may create a factual issue. Cullum Mechanical Constr., Inc. v. S.C. Baptist Hosp., 344 S.C. 423, 433, 544 S.E.2d 838, 842 (2001). Factual issues are resolved by the trier of fact and, in most instances, not on a motion for summary judgment.

One who, being under no duty to do so, takes charge of another who is helpless adequately to aid or protect himself is subject to liability to the other for any harm caused to him by:

- (a) the failure of the actor to exercise reasonable care to secure the safety of the other while within the actor's charge; or
- (b) the actor's discontinuing his aid or protection, if by so doing he leaves the other in a worse position than when the actor took charge of him.

Owen C [REDACTED] was "helpless" and was under CMC's charge during his hospitalization.

Under § 323 or § 324, CMC assumed a duty to Owen even if no duty existed at common law.

b. CMC breached its duty to Owen C [REDACTED]

i. Standard of care for CMC social workers

In a negligence claim, a party breaches its duty by deviating from the applicable standard of care. The standard of care "may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines." Madison v. Babcock Ctr., Inc., 371 S.C. 123, 638 S.E.2d 650 (2006). LCH has internal policies specifically related to actions required by doctors, social workers, and other hospital staff in instances of suspected child abuse or neglect. These policies state the standard of care for the CMC personnel that treated and otherwise cared for Owen Carduff.

CMC policy PR 110.03 sets the standard of care for CMC personnel for "Juveniles Suspected of Being Abused or Neglected." CMC Policy PR 110.03, attached as **EXHIBIT 2** ("Juvenile Abuse Policy"). By its own terms, this policy is intended to set the required course of action "in cases of suspected abuse or neglect." The procedures of this policy certainly applied to Owen's December 2009 hospitalization. Three-month old Owen C [REDACTED] presented to LCH with two subdural hematomas. Owen was transferred to LCH due to an "apparent life threatening event." CMC History & Physical, CMC 0059-0062, attached as **EXHIBIT 3**. CMC policy requires its agents and employees to be suspicious of child abuse for any injury to a child under

six months old. See EXHIBIT 2, at 7 of 23. Thus, the standard of care required CMC to comply with the provisions of the Juvenile Abuse Policy in treating Owen in December 2009.

CMC's Juvenile Abuse Policy imposes several obligations on LCH doctors, social workers and other personnel in the treatment of suspected child abuse victims. First, the DSS office in the child's home county must receive notice of the hospitalization.³ Second, LCH staff must "Complete CHS Suspected Child Abuse and Neglect form (SCAN)" for the patient and document all positive exam findings on a SCAN form. Third, there must be a consult with a "CHS Clinical Care Management Social Worker" for the purpose of conducting an "assessment process." CMC's "Child Abuse and Neglect Algorithm," a flow chart of required activities in suspected child abuse cases, also notes the requirement of a medical social worker's involvement in the assessment and treatment process. Child Abuse and Neglect Algorithm, attached as **EXHIBIT 4**. Regardless of any assessment or investigation required of DSS or law enforcement, CMC policy imposes an independent duty of assessment upon CMC social workers. CMC social worker Laura Newmark acknowledges her job entails certain assessment duties. L. Newmark Dep. 147:3-9, excerpts attached as **EXHIBIT 5**.

The psychosocial assessment must explore certain specific issues to meet the standard of care imposed by the Juvenile Abuse Policy. A CMC social worker must determine whether (1) a child's parents have caused or allowed infliction of a serious physical injury—i.e. whether the suspected victim meets the policy's definition of an "abused juvenile"; (2) parents offer a "logical explanation...consistent with the age, pattern, and severity of the injury"; (3) parents are

³ Hospitals are statutorily required to report suspected child abuse. See N.C. Gen. Stat. § 7B-301 ("Any person or institution who has cause to suspect that any juvenile is abused ...shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found."; S.C. Code Ann. § 63-7-310(A)(requiring any "physician, nurse...or any other medical...professional" to "report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused").

guilty of any “inappropriate parental behaviors” during the child’s hospitalization; and (4) whether it is safe for the child to be discharged back to the parents’ care. Plaintiff’s expert Dr. George Savarese, a licensed social worker, states by affidavit that there are certain “basic elements” of a psychosocial assessment performed by any competent social worker. G. Savarese Aff. at 8. These basic elements include a child’s developmental history and temperament as well as characteristics of the parents including social/financial stressors, demographic risk factors (e.g. age/maturity level, educational history, and socioeconomic status), attitude toward parenting, and any relational issues between mother and father.

The Juvenile Abuse Policy not only requires CMC social workers to include certain issues in psychosocial assessments for suspected child abuse cases, it also requires the social worker to take certain actions in response to an assessment’s results. The Policy is clear that a social worker must respond assertively before a child’s discharge when an assessment indicates a high risk of abuse. This standard of care is distinct from the medical care provided by LCH doctors and nurses. Specifically, the policy states

When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS and the safety plan has been placed on the chart in writing, if applicable.

Juvenile Abuse Policy, EXHIBIT 2 at 3 of 23 (emphasis in original); see also Algorithm, EXHIBIT 4 (same).

Based on an assessment’s results, a social worker must also take efforts to prevent a vulnerable child from being placed in a dangerous environment. If an assessment shows that it is potentially unsafe for a child to be returned to his parents, the social worker should first contact DSS to see whether the department, in concert with law enforcement, will use its authority to

place the child in emergency protective custody.⁴ If an assessment indicates a high risk for abuse and DSS chooses not to intervene, a CMC social worker has a duty to exercise the authority granted by North Carolina law to seek a court order to retain temporary custody of a suspected abuse victim. See N.C. Gen. Stat. § 7B-308. The use of this statute is part of the general duty to use reasonable care in rendering of services to a child. Though a North Carolina Statute, it is what a reasonable hospital and its employees and agents would use in discharging care to a child.

ii. CMC social workers deviated from the standard of care.

CMC social workers breached the standard of care in their assessment, communication, and efforts to intervene on behalf of Owen C. G. Savarese Aff. at 7. CMC social workers Katie Harrison and Laura Newmark combined to conduct a psychosocial assessment ignoring issues CMC policies required them to address and issues any competent assessment would include. Katie Harrison was the weekend social worker who initially worked on Owen's case on December 5th and 6th. Social work's duties were then handed over to Laura Newmark, LCH's weekday social worker. Between these two social workers, the psychosocial assessment of Owen's care totals just six quarter-page entries in Owen's medical record. See CMC 0092-0097, attached as **EXHIBIT 6**. The assessment's brief entries contain "minimal" information and "do[] not explore or probe any of the areas that a competent psychosocial assignment should." G. Savarese Aff. at 9. Plaintiff's experts also note a deviation from the standard in the way in which Ms. Harrison and Ms. Newmark handled the transition from the weekend to the weekdays. Ms. Newmark's entries in the assessment make clear that she simply "rubberstamped" Ms. Harrison's bare-bones assessment while failing to ask the necessary questions to address the family's abuse risk profile. Id.

⁴ Emergency protective custody allows the state to take physical custody of a child for "a temporary period of no more than twenty-four hours to protect the child from imminent danger." S.C. Code Ann. § 63-7-20(9).

The social workers' assessment lacked the breadth and rigor the standard of care required. Ms. Newmark described her investigation of Owen's subdural hematoma as limited to "tak[ing] a history from the parents on [whether] there [had] been any recent trauma." L. Newmark Dep. 36:5-9. The tough yet vital questions were not asked of Owen's parents. For those instances where questions were asked, the social workers were overly deferential to the parents' answers. Ms. Newmark viewed her assessment duty as nothing more than obtaining the parents' "story" regarding the source of the injury and the child's history. See L. Newmark Dep. 162:16-163:2. According to Dr. Savarese, a competent social worker would interview parents and then investigate their claims rather than simply acquiring and accepting a parent's explanation. G. Savarese Aff. at 7.

Ms. Harrison and Ms. Newmark had at their disposal many different options to conduct a competent psychosocial assessment. The social workers should have interviewed extended family members including the paternal grandparents and father's step-brother who could have provided additional context to understand the home environment to which CMC released Owen. Id. at 19. There is no indication that the social workers requested police or prior treatment records for Owen or his parents. Id. Social workers also typically use standardized child abuse screening tools and other "risk assessment instruments" to aid in the assessment process. CMC social workers should have employed these devices in Owen's case. Id. at 20.

The assessment breaches contributed to the social workers' failure to comply with their communication duties. The other participants in Owen's case (DSS and law enforcement) "depend upon the hospital's assessment of risk, which is based on a combination of both medical and psychosocial data." Id. at 29. DSS would have considered input from hospital sources in making DSS case decisions including "any concerns that they have." K. Hinnant Dep. 26:6-12,

excerpts attached as **EXHIBIT 7**. Ms. Newmark acknowledges CMC had a duty to “report to DSS” and “provid[e] them with up-to-date information.” L. Newmark Dep. 35:20. However, by conducting an incomplete, surface level psychosocial assessment, the CMC social workers were not in a position to make the required communications. G. Savarese Aff. at 23. In sum, the social workers were required to “communicate accurately the potential risk of harm to the child” posed by the parents or parental home environment. Ms. Harrison and Ms. Newmark did not make the required communications on this “family risk profile.” Id. at 23.

The Juvenile Abuse Policy and Plaintiff’s experts establish that CMC social workers had a clear responsibility related to a patient’s discharge. Ms. Newmark fails to acknowledge these duties, claiming her responsibility was to be “a liaison between the medical team and DSS.” L. Newmark Dep. 10:24-11:1. Social workers were required to be part of the process in determining Owen’s disposition. Juvenile Abuse Policy, at 3 of 23. Ms. Newmark’s efforts to disavow these responsibilities are concerning from a hospital policy and hospital administration perspective.

Plaintiff’s hospital administration expert J. Kevin Moore notes deviations from the standard of care in the efforts of Ms. Newmark and other CMC agents to deem their actions as reasonable simply because non-accidental trauma was not conclusively established by medical tests. K. Moore Aff. at 3-4, attached as **EXHIBIT 8** (“medical clearance is not synonymous with ‘ready for discharge’ and cannot be treated as such under LCH policy”). Dr. Cheryl Courtlandt, Owen’s treating physician, made clear at her deposition that Owen’s medical tests did not eliminate the possibility that Owen was abused. Dr. Courtlandt testified that some elements presented concern for non-accidental trauma. As a whole, “it could not be determined whether or whether not he had been the victim of child abuse.” C. Courtlandt Dep. 45:13-21, excerpt attached as **EXHIBIT 9**. Additionally, the Juvenile Abuse Policy makes clear, medical

substantiation is only one factor a hospital must consider when determining the conditions of a child's discharge. In circumstances like these, CMC agrees that it should err on the side of caution. C. Courtlandt Dep. 41:1-13. By failing to intervene at Owen's discharge when they knew or should have known the medical tests could not rule out non-accidental trauma, CMC social workers failed to err on the side of caution. K. Moore Aff. at 6 (hospital "failed to take actions which would or could have averted subject exposure to and possibilities for ongoing abuse").

CMC social workers' voices were required in the discharge decision making process. They had a duty to participate in both the development and implementation of a safe discharge plan for Owen. G. Savarese Aff. at 26. An adequate psychosocial assessment of Owen's history and his parents would have led a competent social worker to realize the high risk of maltreatment posed by the environment to which Owen was to be released. Even CMC's substandard assessment led to some suspicions of abuse as indicated by CMC's decision to post a sitter in Owen's room. K. Moore Aff. at 3-4. Yet, when the time came for the social workers to intervene so as not to place Owen back into the unsupervised custody of his parents, CMC failed. There were many available options the social workers could have recommended including relative placement, supervised parental visitation, and a delay in discharge. G. Savarese Aff. at 26. Additionally, the hospital was empowered by law to seek emergency temporary custody of Owen to prevent his release to a high-risk environment. Just as they had in their duties to assess and communicate, CMC personnel failed in their duty to intervene on behalf of the three-month old child in their care.

c. CMC's conduct proximately caused Owen C [REDACTED]'s damages.

Proximate causation is an essential element of any negligence cause of action. Burnett v. Family Kingdom, Inc., 387 S.C. 183, 191, 691 S.E.2d 170, 175 (Ct. App. 2010). This element requires proof of both “causation in fact and legal cause.” Small v. Pioneer Mach., Inc., 329 S.C. 448, 463, 494 S.E.2d 835, 842 (Ct. App. 1987)(citing Hurd v. Williamsburg County, 363 S.C. 421, 428, 611 S.E.2d 488, 492 (2005)). Causation in fact is established by proof that the injury “would not have occurred but for the defendant’s negligence.” Cody P. v. Bank of Am., N.A., 395 S.C. 611, 620, 720 S.E.2d 473, 478 (Ct. App. 2011)(citing Mellen v. Lane, 377 S.C. 267, 278, 659 S.E.2d 236, 245 (Ct. App. 2008). Legal cause is established by determining foreseeability, a factor which focuses on “whether the injury is the natural and probable consequence of the alleged negligent act.” Id. As the Cooke court noted, “[p]roximate cause is generally a question for the jury.” 741 F. Supp. at 1214; see also Ballou v. Sigma Nu Gen. Fraternity, 291 S.C. 140, 147, 352 S.E.2d 488, 493 (Ct. App. 1986)(“Only in rare or exceptional cases may the question of proximate cause be decided as a matter of law”). Summary judgment on proximate cause is inappropriate where the plaintiff has produced “some evidence.” Cooke, 741 F. Supp. at 1214.

In this case, CMC social workers breached the standard of care applicable to their assessment, communication, and intervention. As a direct and proximate result of those breaches, Owen C [REDACTED] has suffered severe brain injuries and impairments with which he must deal for the rest of his life. The “causal chain” leading to Owen’s current condition started with the grossly insufficient psychosocial assessment performed by CMC social workers. G. Savarese Aff. at 30. A competent assessment would have contained information CMC was under a duty to communicate to Owen’s medical team, DSS, and law enforcement. There was pertinent

information easily available to Ms. Harrison and Ms. Newmark had they properly performed their assessment responsibilities. Id. at 11. This is evident from the information obtained when a fuller inquiry was undertaken after the January 2010 injury. Michael Carduff acknowledged that his relationship with Kayla was strained since Owen's birth, Kayla acknowledged Michael's poor parenting skills and apathy toward Owen, and the maternal grandmother reported stress between the grandparents and Kayla regarding Michael's conduct and disposition toward Owen. Id. at 11-14.

A proper assessment would have revealed these facts and would have been included in the information communicated to other decision makers and used by the social workers in meeting their duty to decide on the disposition of the patient. Instead, "dangerously inaccurate information was communicated, beginning with the hospital's social worker's deficient assessment of the psychosocial risk factors and her lack of comprehension of the resulting inherently high-risk of potential harm to the child." Id. at 30. CMC social workers not only failed to acquire needed information during their assessment, they also failed to properly construe the evidence right before their eyes. Owen was admitted to LCH with a subdural hematoma for which his parents could not offer a satisfactory explanation. While medical tests for non-accidental trauma were inconclusive, construing these results as conclusive evidence of an accidental injury is not a reasonable response. The night before Owen was discharged, CMC neurosurgeon noted Owen was, from a medical perspective, ready for discharge but only "under supervision." CMC 0039, attached as **EXHIBIT 10**.

Had this information been collected, properly analyzed, properly communicated, and properly utilized in December 2009, Owen would not have been discharged to his parents without supervision. Instead, he would have been taken into emergency protective custody by

South Carolina authorities, remained at LCH under the procedures outlined in North Carolina law, or discharged to some caregiver other than his parents. More likely than not, Owen would not have been in Michael Carduff's custody in January 2010 when Michael inflicted the injuries from which Owen currently suffers. See G. Savarese Aff. at 30 (concluding that but for CMC's standard of care breaches "it is more likely than not this child would have been placed into custody with some other person than the custodial parents and the tragic situation in January 2010 would have been avoided").

Plaintiff anticipates CMC may claim any chain of causation between its conduct and Owen's injuries is severed by the intervening criminal act of Michael Carduff, an individual over which CMC lacks control. However, the intervening criminal act of a third party does not automatically sever the causal chain between a defendant's negligent conduct and a plaintiff's injuries. In fact, "where the injury at the hand of the intervening party was within the general range of consequences which any reasonable person might foresee as a natural and probable consequence of the negligent act," then the defendant remains a proximate cause. Shepard v. S.C. Dep't of Corr., 299 S.C. 370, 375, 375 S.E.2d 37, 37 (Ct. App. 1989). Plaintiff need not prove the "particular chain of events" was foreseeable but only that the injury the criminal inflicted was "within the general range of consequences which any reasonable person might foresee." Cody P., 395 S.C. at 621, 720 S.E.2d at 478 (citing Shepard 299 S.C. at 375, 385 S.E.2d at 38). It was very foreseeable that allowing Owen to be returned to the care of the person(s) most likely responsible for causing the brain injury diagnosed on December 5, 2009 would lead to further injury or even death.

Several different types of evidence may be used to demonstrate that a defendant could reasonably foresee injuries ultimately perpetrated by the criminal act of an independent third

party. Expert testimony may be used to establish foreseeability. An expert with knowledge of the defendant's business may testify regarding the types of harms the defendant anticipates in its business. See Cody P., 395 S.C. at 621-22, 720 S.E.2d at 478 (considering banking expert's testimony that banks anticipate theft). The defendant's policies and procedures may also demonstrate that it foresees certain types of harms may flow from its negligent conduct. In Cody P., the defendant's policies and procedures established rules to guard against certain harms. Id. at 622, 720 S.E.2d at 478. The policies themselves were some evidence that the defendant foresaw the types of harms it took the time and effort to guard against. Id.

Child abuse at the hand of a child's parent lies at the core of what the Juvenile Abuse Policy is designed to prevent. Before a child is discharged from the hospital, the Policy requires consideration of whether "it is unsafe for the juvenile to return to his or her parent." **EXHIBIT** , at 3 of 23. Competent social workers in the position of Ms. Harrison and Ms. Newmark recognize that their work is designed to prevent caretaker abuse of vulnerable children. They also recognize the risk of child abuse associated with "plac[ing] the child under the control of the two primary suspected potential perpetrators." G. Savarese Aff. at 29. Michael Carduff's January 2010 conduct was foreseeable to CMC and does not break the chain of causation between CMC's negligence and Owen's injuries.

2. CMC is not entitled to immunity under S.C. Code Ann. § 63-7-390.

The South Carolina Children's Code requires certain classes of individuals to report instances of suspected child abuse or neglect to DSS or law enforcement. S.C. Code Ann. § 63-7-310(A), (D). The duty to report applies to any "physician," "nurse," "medical...professional," and "social or public assistance worker." Id. An individual subject to § 63-7-310's duty who fails to report suspected abuse or neglect may face criminal liability. S.C. Code Ann. § 63-7-410. The

Children's Code also confers immunity on mandatory reporters for civil and criminal liability arising from the performance of their reporting duty. S.C. Code Ann. § 63-7-390. CMC claims the immunity provision entitles it to summary judgment on Plaintiff's negligence claim. However, the conduct underlying Plaintiff's claim does not fall within the immunity's scope and summary judgment on this basis must be denied.

To embolden various professionals interacting with children to meet their statutory obligation and help DSS/police address the public welfare problem of child abuse and neglect, immunity is provided for claims related to a report of suspected child abuse. The immunity provision's limited reach is clear from its language. Under § 63-7-390, a "person required or permitted to report...is immune from civil and criminal liability which might otherwise result by reason of these actions." The proper construction of this statute clearly indicates that immunity is limited. See In re Campbell, 379 S.C. 593, 599-600, 666 S.E.2d 908, 911 (2008)("The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature"). Legislative intent "should be ascertained primarily from the plain language of the statute." Thompson v. Cisson Constr. Co., 377 S.C. 137, 157, 659 S.E.2d 171, 181 (Ct. App. 2008). The statute's plain language indicates the immunity is limited to "these actions," i.e. actions described and mandated by § 63-7-310 and other provisions within the same article of the Children's Code.

This immunity provision is not intended to provide reporters blanket immunity for post-report conduct. Recognizing the statute's plain language, the South Carolina Attorney General's office has concluded the immunity applies only "for reports made of abuse or neglect." Op. S.C. Att'y Gen. 06-22 (Jan. 26, 2006); see also Op. S.C. Att'y Gen. 04-6 (Jan. 7, 2004)(statute provides immunity for reporter "by reason of his or her reporting in good faith" suspected

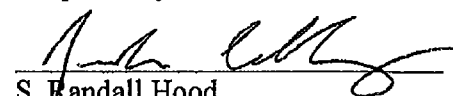
effective reporting system and encouraging the reporting of children in need of protection.” See Op. S.C. Att’y Gen. (June 22, 1990). Conferring immunity to CMC for alleged violation of its common law and internal policy duties to assess a patient’s potential discharge environment does nothing to protect children or encourage reports of suspected child abuse.

Reporter immunity is designed to prevent claims against a reporter based on the report’s veracity or the reporter’s motivation. The statutory language supports this view in that it includes a rebuttable presumption of good faith. To support the statutory goal of encouraging reports of even “suspected” child abuse, the legislature grants reporters immunity from defamation, emotional distress, and privacy tort claims for good faith reports and further installed a presumption of good faith. See Williams, 379 S.C. at 532, 665 S.E.2d at 244 (applying reporter immunity to defamation and intentional infliction of emotional distress claims). This strikes the proper balance between encouraging reports and preventing vindictive, bad faith reports. In sum, Plaintiff’s negligence claim against CMC does not allege conduct covered by the reporter’s immunity and the immunity provision does not apply to this case.

CONCLUSION

Based on the arguments stated above, Plaintiff respectfully requests that the Court deny CMC’s Motion for Summary Judgment. Plaintiff has presented competent evidence on all required elements of her negligence claim against CMC. Additionally, CMC is not entitled to immunity under S.C. Code Ann. § 63-7-390.

Respectfully submitted,



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April 17, 2013
Rock Hill, South Carolina

In re: Elizabeth Hope Rainey (Guardian Ad Litem to Owen C. [REDACTED])
v. Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas
Medical Center (CMC), et. al.

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Note: This affidavit with findings is propounded with a focus on the hospital social workers' role in Owen C. [REDACTED]'s care during the December, 2009 hospitalization, in order to determine if those actions were consistent with the applicable standards of care along the dimensions of Assessment, Communication, Intervention, and Documentation. A second affidavit can be propounded with a focus on DSS and Law enforcement actions in regard to the investigation, care and diligence of the state agencies in regard to their actions or inactions concerning Owen C. [REDACTED].

Section I outlines the basic facts of the case. Section II identifies the applicable standards of care with regard to the social workers' actions. Section III outlines the deviations from those standards of care with supporting documentation in the case record. Section IV provides a conclusion.

I. Summary of Facts of Case

On December 5, 2009, Owen C. [REDACTED], a 3-month old infant child, was brought by car by his parents to Piedmont Medical Center after going "limp" in his father's arms shortly before the child's mother returned home from work. The child was later transferred to Carolinas Medical Center (CMC) where he was subsequently admitted. A CT scan revealed subdural hematomas that raised the suspicion of non-accidental trauma. Medical and psychosocial assessments were conducted by the hospital. While the child was still hospitalized, a referral to the Department of Social Services (DSS) was initiated to investigate the case. Unable to conclusively rule out non-accidental trauma, on December 8, 2009, the child was discharged back to the parent's home under their supervision. On January 11, 2010, the child returned to CMC having sustained more severe injuries.

II. Applicable Standards of Care

The following documents embody the practice standards, guidelines, and indicators reflecting the applicable standards of care related to the social workers' actions within the context of the hospital's multi-disciplinary team:

National Association of Social Workers (NASW) "Code of Ethics" (2008)

National Association of Social Workers (NASW) "Standards for Clinical Social Work in Social Work Practice" (2005)

National Association of Social Workers (NASW) "Standards for Social Work Practice in Health Care Settings" (2005)

National Association of Social Workers (NASW) "Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital" (1990)

The specific standards are outlined below, grouped by the domains of Assessment, Communication, Intervention, and Documentation corresponding to the key areas upon which the findings of this evaluation are based, as outlined in Section III.

ASSESSMENT

NASW Code of Ethics
Section 4.01: Competence

Social workers should strive to become and remain proficient in professional practice and the performance of professional functions.

NASW Standards for Clinical Social Work in Social Work Practice
Standard 2: Specialized Practice Skills and Interventions

Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical interventions with individuals, families, couple, and groups...They shall be familiar with social, psychological, cultural, and health factors that influence the mental, emotional, and behavioral functioning of the client...They shall have the ability to gather and interpret social, personal, environmental, and health information... evaluate and treat problems within their scope of practice... [and] collaborate effectively with other social workers or allied professionals, when appropriate... They shall be accountable for all aspects of their professional judgment, behavior, and decisions.

Pre-revised Version (1989 to 2005): Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions... including the ability to ...obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis.

NASW Standards for Social Work Practice in Health Care Settings
Standard 5: Knowledge

Social workers in health care settings shall demonstrate a working knowledge of current theory and practice and integrate such information into practice...Essential areas of knowledge and understanding about health care include: the biopsychosocial needs of clients and families, the psychological... needs of clients and families and how to ensure that they can be addressed.

NASW Standards for Social Work Practice in Health Care Settings
Standard 6: Assessment

Social workers shall provide ongoing assessment, including gathering comprehensive information to use in developing interventions and treatment strategies.

COMMUNICATION

NASW Code of Ethics
Section 2.03: Interdisciplinary Collaboration

Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that effect well-being of client's by drawing on perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established...Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels.

NASW Code of Ethics
Section 2.05: Consultation

Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interest of clients.

NASW Standards for Social Work Practice in Health Care Settings
Standard 11: Teamwork and Collaboration

Social workers shall participate in care teams and collaborate with other professionals, volunteers, and groups in and outside of their practice setting to enhance all aspects of the client and family system's care...Social workers participate in multiple care teams, which are typically interdisciplinary. As part of such teams and collaborations, social workers shall demonstrate the ability to...ensure that the social work role and responsibilities are clearly delineated and communicated to other members of the team.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 5: Teamwork

Patient discharge occurs with the knowledge of the social worker coordinating discharge planning...Social workers are responsible for coordination of patient's discharge plans, especially when post-hospital care is required.

INTERVENTION

NASW Code of Ethics
Section 1.16: Termination of Services

Social workers should terminate services to clients...when such services are no longer required or no longer serve the client's needs or interests...Social workers should take reasonable steps to avoid abandoning clients who are still in need of services... [should give] careful consideration to all factors in the situation [and] taking care to minimize possible adverse effects... [and] should assist in making appropriate arrangements for continuation of services when necessary.

NASW Code of Ethics
Section 2.06: Referral for Services

Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional

service is required...Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

NASW Standards for Clinical Social Work in Social Work Practice
Standard 3: Referrals

Clinical social workers shall be knowledgeable about community resources and make appropriate referrals, as needed...They shall maintain collaborative contacts with social work or other related professionals and make appropriate referrals, as needed.

Pre-revised Version (1989 to 2005): Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients...When a client is being served by other agencies, the clinical social worker shall maintain collaborative contacts as necessary with the other providers to ensure the coordination of services and the client's receipt of optimal benefits from the various services...When the client is involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility.

NASW Standards for Social Work Practice in Health Care Settings
Standard 7: Intervention and Treatment

Social workers implement intervention and treatment plans that promote client well-being and ensure a continuum of care. Planning shall be based on a comprehensive, culturally-competent assessment with interdisciplinary input...Intervention and treatment plans include strategies to address needs identified in the assessment...discharge planning...[and] client and systems advocacy.

NASW Standards for Social Work Practice in Health Care Settings
Standard 10: Client and Community Education

Social workers act as educators for clients, families, the community, and other professionals regarding disease prevention, impact of the illness and disease progression, advocacy for benefits, health maintenance, and adherence to treatment regimens...Assessment identifies the educational needs based on the expressed needs of individuals, family members, and significant others. The social worker identifies deficiencies in the

knowledge base of the client and works with the client to obtain the needed information and resources.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Indicator 6: Readmissions with Social Complications

Patients are readmitted with social complications. Social workers are responsible for ensuring that patients receive the immediate post-hospital care they need and adapt to the post-hospital setting. Readmission of too many patients due to social complications suggests either that they did not receive social work services or that these services were inadequate.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Indicator 1: Follow-Up

Patient discharge care is assessed following discharge. Patients who are at high risk for developing problems with post-discharge care should receive a follow-up assessment after discharge to determine whether the aftercare plan is being implemented as planned.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Indicator 2: Problem Resolution

Patient's medically related psychosocial problems are ameliorated. The intent of social work intervention is to improve or resolve patients' psychosocial problems related to their medical care. Problem improvement or resolution is an indicator of whether the intervention has achieved its goal.

DOCUMENTATION

*NASW Standards for Clinical Social Work in Social Work Practice,
Standard 8: Documentation*

Documentation of services provided to, or on behalf of, the client shall be recorded in the client's file or record of services...Documentation must reflect an accurate account of services. Progress notes, reports, and summaries of services shall be regularly recorded in the client's file.

III. Specific Deviations from Standards of Care

The specific deviations from the above standards of care by CMC employees (with a specific focus on the hospital social workers) can be understood as occurring in four primary domains: Assessment, Communication, Intervention, and Documentation. These deviations include the following:

ASSESSMENT

Failure to conduct an independent, appropriate, and complete psychosocial assessment within the institutional hospital setting

- [Did you make any clinical assessment of either parent to determine if either were a risk of being or becoming abusers of their child?] "My interaction with them [the parents] would have been more brief than Katie's [Katie Harrison, MSW] was...because their story about the admission would have already been told and DSS would have already been involved, so generally we don't continue to ask them to share the story over and over again." [NEWMARK 162:20]

Comments: It is clear that the social worker believes that her assessment is limited to simply obtaining the parents' "story" of what happened. This grossly minimizes the critical social work role of conducting a comprehensive psychosocial assessment, which includes assessing the risk potential for harm to the child in order to facilitate a safe discharge. The purpose of the psychosocial assessment is to gain a thorough understanding of the factors that may contribute to circumstances or conditions which could reasonably result in abuse/neglect or a significant risk of harm to the child. From a continuity of care perspective, by reading the weekend social worker's note [Katie Harrison, MSW], Ms. Newmark should have seen that the information contained in that initial assessment was minimal and that further assessment was necessary in this regard.

- CMC Policy & Procedures indicate that in cases with juveniles suspected of being abused or neglected the clinical team must "Consult CHS (Carolinas Healthcare System) Clinical Care Management Social Worker to aid in the assessment process...Utilize your hospital MSW's during regular business hours." [NEWMARK Exhibit 10]

Comments: Based on the hospital's own policies and procedures, the social workers' role and responsibility to conduct a comprehensive psychosocial assessment are clearly outlined.

- "The presence of risk factors should not be used as indicators of child abuse but rather to provide guidance in prevention strategies as well as management and treatment plans." [COURTLAND Exhibit 14] ["A careful and well-documented history is one of the most critical elements of the medical evaluation, right?" "Yes." [COURTLAND 90:18]

Comments: It is the role of the social worker to assess the presence of psychosocial risk factors in the patient's past and present history that are used to develop the risk profile in conjunction with the medical evidence. Factors which constitute the basic elements of a psychosocial assessment (which is the specific purview of the social worker), include a developmental history, pregnancy history, familial patterns of discipline, the child's temperament, social and financial stressors, demographic risk factors, parental attitudes, marital/relational issues, etc. The risk profile is then used to guide the discharge plan with regard to the level of precaution necessary to protect the child from harm. The social worker doesn't have to "solve the case" regarding abuse, per se. The social work role is to assess and comprehend the risk profile then communicate to the hospital multi-disciplinary team and outside agencies the proper degree of inherent risk based on the psychosocial assessment.

- Laura Newmark, MSW, and Katie Harrison, MSW were the two key hospital social workers involved in the case. Ms. Harrison, the weekend social worker, has a total of 4 progress notes (dated 12/06/09). Taken together, they comprise her entire psychosocial assessment. Ms. Newmark has 2 progress notes.

With regard to Katie Harrison's assessment, the relevant psychosocial information in her 4 progress notes (dated 12/06/09) includes: "...parents do not have a home phone...Parents report that on Wednesday (12/02/09) parents noticed...baby...screaming non-stop...patient...went limp but was still breathing...patient has blood on the right side of his brain...Parents deny any trauma, that anyone dropped the baby, patient's birth was normal, full-term. Baby is only watched by parents and maternal grandmother, no daycare...baby does have South Carolina Medicaid, WIC, mom has food stamps...Both parents work... Maternal grandmother watches baby when parents are working...RN Sara did report that maternal grandmother did tell her privately that when she had picked up baby from dad and uncle that she noticed baby had a bump on his head, she asked dad and uncle about this and dad and uncle stated they had no idea why this happened...MSW will follow as needed." [NEWMARK Exhibit 1]

With regard to Laura Newmark's assessment, the relevant psychosocial information in her 2 progress notes (dated 12/07/09) includes:
"...anticipate discharge hopefully this date. Owen lives with parents, no other children, does have Medicaid, WIC, transportation, frequent babysitting with maternal grandmother. Both parents employed, father has finished 10th grade, mother 11th. MSW discussed safe sleeping, other parenting education available for parents prior to discharge...will follow for safe discharge plan. Updated RN, MD." [NEWMARK Exhibit 1]

Comments: In effect, Ms. Newmark "rubberstamped" Ms. Harrison's assessment. She did not add any additional information to the chart that addressed the risk profile. Essentially, both social workers abrogated their professional duty to conduct a competent comprehensive psychosocial assessment, essentially leaving the task to be done by DSS. The information contained in the total of 6 progress notes is minimal and does not explore or probe any of the areas that a competent psychosocial assessment should, particularly in a case involving potential child abuse. This is not to say that it was not appropriate for DSS to conduct their own investigation of the case, but rather to point out that the hospital social workers have a duty to conduct a comprehensive independent psychosocial assessment as well. Despite the fact that the psychosocial assessment did not address the necessary areas, the information that was contained in the social work progress notes and in the patient's medical chart contained enough facts that indicated a high risk of harm to the child which was not recognized by the social workers. These facts are listed below.

Failure to comprehend the high-risk profile for child abuse despite the presence of numerous evidence-based clinical markers

Markers that were identified in the social workers psychosocial assessment based on interviews with parents and a review of the medical chart:

- The medical findings of subdural hematomas (bleeding of the brain) that could not be explained medically
- The possibility of non-accidental trauma could not be conclusively ruled out
- Parental explanations that did not adequately explain the injury [COURTLAND 35:7]
- A delay of 8-10 minutes to do anything at all when they thought the child "was dead" and "went limp". "Owen lethargic, not responsive and we thought he was dead." [DSS 00143]

- No call to 911/ambulance, instead driving the child to ER (*The parents had no home phone but did have a cell phone; they said they "thought it would take too long for the ambulance to arrive."*)
- No witnesses to corroborate father's story
- Father was the last person alone with the child when the injury occurred
- Adolescent, unmarried parents
- Low socioeconomic status of parents
- Low education level of parents
- An unidentified babysitter was reported to have been involved with the child on the Thursday preceding the injury
- Child "screaming non-stop"; "crying incessantly", "irritable", "fussy"; "increased crying episodes" [COURTLAND 34:8; 98:7] in weeks preceding injury (*An inconsolable child is a classic trigger for child abuse.*)

Comments: These factors noted above, when considered together, should have served at a minimum, to reflect a risk profile consistent with the strong possibility of child abuse. As such, the need for safety precautions should have been regarded as high from the point of admission. Given the risk profile noted and the fact that non-accidental trauma could not be definitively ruled out, the social workers should have erred on the side of caution in the discharge planning process.

- "I don't think we can predict the future on what is or what isn't going to happen in working with DSS." [NEWMARK 84:21]

Comments: This is the very reason why the standard of care in practice is to err on the side of caution, which was not done in this case.

- "I don't agree that the parents were suspected [of child abuse]. A report was made and in terms of erring on the side of caution, we'd rather make the report to DSS than not and hope that DSS can do a complete follow-up that we can't do here in the hospital." [NEWMARK 125:19]

Comments: How the social worker could not agree with the fact that the parents were suspected of abuse is difficult to understand. The fact that the physicians could not rule out NAT by default indicates that there was still a suspicion of abuse. The problem is that the social worker herself did not recognize this inherent risk and diminished it to the extent that all of her subsequent involvement in the case was predicated on this perception of diminished risk. Additionally, there was no reason that the social worker was unable to do a competent psychosocial assessment in the hospital. Given a four day hospitalization and full access to the family, the social worker had more than ample opportunity to interview the principle persons involved. Although assessing the home environment was

important, it was not necessary to formulate an appropriate discharge plan given the risk profile presented in the hospital. The social worker simply deferred her professional responsibilities to DSS.

Markers that were not known due to lack of probing/exploring in interviews with parents and other available collateral sources:

If the parents were independently assessed properly by the social workers (and/or DSS), collateral sources were interviewed, records were obtained, and standardized instruments were utilized, the following additional information would potentially have been elicited, indicating even a higher degree of risk in sending the child home to the parents:

Information available from Michael Carduff (father)

- "In the past, I would get frustrated with Owen's crying and pat him in the back hard." [DSS 00176]

Comments: Michael admitted this to the detective after the second hospitalization. If properly interviewed by the social workers, this information may have been recognized.

- "Since Owen came along mine and Kayla's relationship has been a little stressed." [DSS 00179]

Comments: The relational stress is noted.

- Michael told police he was charged with possession of stolen goods at age 16...Michael said that since Owen came along, things have been a little stressed... Michael told police he was charged with possession of stolen goods at age 16..." [SHER 000027-28]

Comments: Relational stress and a criminal history are risk factors for child abuse.

Information available from Kayla Lythgoe (mother)

- "Like any typical man, Michael never wanted to change diapers...he did get nervous when he had to be alone with him [Owen]...After he'd burp him and couldn't figure out [how to stop him from crying] he'd usually just bring him to me...Michael lost his job just after Owen was born...[Kayla's mother] did not hold [Michael] in high regard...[Charlotte's attitude] created "a little" stress between [us]...Michael would be rough with Owen, picking him up, forget to support his head, swoop him up super fast, at

two months he would do up and down [bouncing him on his knee] with him...I was worried about it. It just scared me...he wasn't aware of how fragile a child could be...[Owen could not turn over and hit the side of the crib because]...he was not that advanced...Michael not working at Food Lion after October [2009] became a source of stress for us...[Michael lost his job after he] "never went back" [one day that he took off to see his parents]...Michael would complain that he hated his manager and that the manager hated him...After getting fired, Michael never looked for a job. He got very lazy...I would yell all the time and he'd yell at me for being a nag...Michael got frustrated over [Kayla] nagging him about not working...He was always playing video games all day...[The week before 12/04/09, Owen] had been acting weird...it was constant crying...crying, crying, crying....Owen was more of a bother than a good thing when [Michael's] friends were over...[Arguments would occur about] ...you're not showing any incentive of being a man, you're being lazy, you're friends are always here, this is not a party house..." [LYTHGOE 41:12-13, 41:21-23, 42:12-16, 43:4-6, 43:7-9, 43:12-25, 44:3-23, 45:16-18, 47:4-9, 47:12-20, 48:9-11, 50:4-9, 50:20-22, 57:7-8, 57:17-21, 62:23-24, 64:20-21, 87:7-18]

Comments: The information obtained in Kayla's deposition was available to the hospital social worker if a proper assessment was conducted in a proactive manner. The facts stated by the child's mother clearly reflect a wide number and range of familial stressors and risk factors for potential abuse of a child, particularly a classic trigger for abuse, the non-stop crying. All of this information was available for consideration by the social worker, the hospital team, DSS, and law enforcement had a competent psychosocial assessment been completed, then communicated to the appropriate collateral agencies.

- A psychological evaluation of Owen's mother, Kayla, conducted after the child was re-injured in January, 2010, indicates that her mother (Charlotte Williams, the child's grandmother) was married three times, Kayla witnessed physical abuse of her mother at the hands of her father on a weekly basis till around age 11, that Kayla was very immature emotionally, had poor insight and judgment, excessive dependency issues with men, and was diagnosed with Dependent Personality Disorder. [DEF PROD 00219-227]

Comments: The implications of these findings suggests a higher risk for the child, especially given the mother's propensity to possibly "look the other way" given her emotional needs and deficits. This is critical information that could have been elicited by the social worker either by a direct, more in-depth interview, or by simply making a psychological

referral to administer some basic surveys or psychological testing, given the suspicion of abuse.

- [Kayla stated regarding the mark her mother [Charlotte Williams, Owen's maternal grandmother] observed in November, 2009]: "Michael said he hit himself with some keys (toy). It was on a Saturday and both she and her mother were upset about this incident. She was upset at MGM for asking questions about the baby having scratches/marks when she did not know where they came from." [DSS 00247]

Comments: The noted presence of a bruise observed just prior to the recent injuries is a marker for abuse.

- "Owens behavior changed on 11/28/09. He was sleeping a lot and screamed when awake, non-stop...The week before 12/04/09 the child was crying a lot." [DSS 00236]

Comments: This is a classic trigger for SBS. Had this been assessed, the risk would have been understood.

- "Kayla has no bonding with Owen, does not ask questions, plays with his toys." [DSS 00237]

Comments: If the maternal relationship with the child had been explored in more depth, this information may have been available.

- "Kayla is back and forth (from the hospital) and she usually does not bond with the child...MGM is the only one there (at the hospital) with the child...the child needs to be in foster care and the foster care parent needs to be the one at the hospital instead of the family." [DSS 00251]

Comments: Why wasn't a parental bonding evaluation (or other surveys) done at the first hospitalization to look at these types of issues in determining the safety of DC home to parents in the face of the suspected NAT/SBS?

- "Kayla could not determine what happened to Owen in December. Kayla never paid attention to the marks. Kayla depends on her mother to make decisions for the child. Kayla appears immature. She does not bond with Owen and usually sleeps the entire time." [DSS 00237]

Comments: Additional Important Information.

- [Regarding discipline]: "When Kayla becomes frustrated she calls her mother." [DSS 00248]

Comments: Reflects the immature dependency on her mother, which in turn reflects a higher degree of risk for returning the child home without a proper safety plan.

- "...[S]ometimes Michael picks up Owen too quick or handles him too rough, I have to tell him to be easy...Michael never got up with Owen or helped with him unless I asked...It seems that everything happened bad to Owen that he was in Michael's care...[My] mother never liked Michael and that she disliked how he looked...he was lazy and a kid and that she could do better...I think if we had gotten the parenting classes that this may not have happened...Michael never talks to the baby at home." [SHER 000019-23]

Comments: This information was elicited by the police after the second hospitalization, however, it describes behavior that occurred before the first hospitalization. Had the social worker properly interviewed the child's mother, Kayla, this information may have been made available.

Information available from Charlotte Williams (maternal grandmother)

- "Michael was not working...This was a point of stress for Kayla...I had reservations about Michael being my daughter's mate...Kayla could do better than him...He played video games and was not working...he was not a good provider...Kayla would say 'don't start' [nagging me about Michael]...This became a stressor for Michael also." [C WILLIAMS 114:7-13, 114:18-20, 114:23-24, 115:7-12, 116:1-8]

Comments: Additional information that was available with a proper interview by the social worker, supportive of a high-risk profile for possible abuse.

- "I knew this was coming" [C WILLIAMS 154:2-8]

Comments: This statement was made to the detective, Amanda Carter, after the child was re-injured in January, 2010. Although Charlotte Williams attributes this to being "angry" and "scared", it does reveal some of her underlying feelings that, if properly assessed in the hands of a skilled social worker, could have helped to further support the nature of the high risk profile.

- As early as November, 2009 (one month prior to the first hospitalization in December, 2009) MGM had suspicions about Michael being abusive toward Owen. She noted a bruise on his forehead and a scratch and only Michael and his brother Brian had the baby all day; Michael is rough with the baby; Michael needs to be reminded to pick up the baby's head; when confronted by MGM about Michael's inappropriate ways of managing Owen, Kayla's reaction was "oh, don't start that again!"; Michael never talked to the baby at home; Michael plays video games 24/7 with his brother; "Kayla is protecting Michael"; Kayla kicked Michael out of house after the first incident and he lost his job; the parents usually just stick Owen in the swing all day; MGM never saw Michael rock Owen in the rocking chair. [DSS 00171, DEF PROD 00199, 00235, DSSYS0049]

Comments: Had this information been elicited, all of these issues reflect serious concerns regarding the safety of the child with the parents, especially the father.

- [Regarding the observed bruises by MGM in November, 2009]: "She took a picture of the bruise." Michael and Brian had the baby that day. This was the week prior to the first hospitalization. "Owen was crying a lot". The child was taken to the doctor at Sunshine Pediatric Center and was told he had a throat infection.

Comments: If maternal grandmother (MGM) was adequately interviewed, this picture would have raised the need for safety precautions given a prior history of possible abuse. The defense will say MGM should have reported this in December—and she should have. She may have not been sure, not certain this was the case, did not want to believe it, not remembered in the stress of the moment, etc. But she should have been asked and adequately interviewed in order to elicit this information. This is the responsibility of the social worker to get the big picture through an independent assessment.

- Lynn Meyers, LCSW, the hospital "Child Maltreatment Coordinator" (at the time of the 2nd hospitalization): "expressed concerns (to the DSS caseworker) that MGM may have known about Owen and being shaken. The MGM told hospital staff that she has seen bruises on the child." [DSS 00271]

Comments: Although this is at the time of the second hospitalization, the MGM also had concerns in November, 2009 about bruises/scratches. This information should have been elicited in December, 2009.

- [Kayla reported to DSS that] "MGM never liked Michael because of the way he looked and he was a lazy kid and felt she could do better. MGM always disagreed with Michael" [DSS 00248]

Comments: Issues in how the grandmother perceived Michael were relevant in understanding the risk profile.

- MGM noted to have a criminal history (misdemeanors) including unlawful alcohol concentration, no proof of insurance of vehicle, simple assault. [DSS 00219]

Comments: If MGM had been appropriately interviewed and her background checked, such information would have been noted raising the risk profile while also ruling out the child's grandmother for an alternative placement at discharge.

- "I think that [Michael] cared for Owen when he had to." [C WILLIAMS, 105:22-25]

Comments: Suggests a need to be told to take care of the child.

Information available from Larry Williams (maternal step-grandfather)

- "I know Owen was crying a lot...It even got to the point that I told Charlotte that [Michael] needs to be a responsible dad and take on responsibility himself...Looking back there probably were some signs but we were just too involved in it...we just missed those signs." [L WILLIAMS 34:22-25, 65:4-6, 69:12-15]

Comments: Further support for one of the common triggers of abuse, particularly in the context of the other risk factors noted as well as the father's lack of responsibility. The vague sense that "there probably were some signs" might have been more fully elicited had the social worker probed and explored these concerns properly.

Misunderstood observations and/or assumptions of low risk:

- [The general findings of no conclusive medical evidence of non-accidental trauma (NAT)].

Comments: The absence of evidence of NAT does not de facto mean it was therefore accidental trauma (AT). It simply means we do not know and the presumption of risk must still be maintained and offset in the discharge plan.

- [Findings of a negative skeletal survey] [COURTLAND 45:15-24]

Comments: The absence of fractures does not equate with the absence of abuse. The abuse may have been of insufficient intensity to cause fractures per se. Thus, the risk is not diminished.

- Parents observed to be "involved, appropriate, good eye contact, loving...while in hospital." [COURTLAND 36:3-8]

Comments: This was under the constant monitored supervision and structure of a hospital sitter and not indicative of how they might act in the unmonitored, unstructured environment at home, thus not supportive of a determination of lower risk.

- "They think that maybe nobody was supervising him and he bumped his head or they were holding him and walking around the door and banged his head or something." [HINNANT 83:25, 84:1-3]

Comments: The risk assessment should be based on known facts not conjecture. In the absence of known facts, if an assumption must be made, the practitioner should err on the side of caution in making assumptions (i.e., that it possibly is NAT). Instead, this assumes that the injury was accidental.

- [The hospital staff] "...thought that DSS was there to release the sitter so they could...go home, and there was no concerns for the child, that it was accidental." [AUDIO TRANSCRIPTS, LOLA DSS PART 1, 12/17/09]

Comments: Again, the notion that the child's injuries were likely accidental was communicated to DSS by the hospital social worker.

- "Laura [Newmark, the hospital social worker] stated at this point there are no obvious signs of abuse or neglect, but they were going to follow-up with the family in two weeks. [AUDIO TRANSCRIPTS, LOLA DSS PART 1, 12/17/09]

Comments: There are not always obvious signs of abuse or neglect. This is why the psychosocial assessment of risk factors that examine the potential are so critical in establishing the appropriate level of safety precautions to take.

- "...by asking for a child maltreatment evaluation...getting DSS and law enforcement involved...That's how you err on the side of caution." [COURTLAND, 41:7-13]

Comments: These are appropriate steps to take but not adequate or cautious enough to address the unknown variables and lag period that would follow while DSS completed its investigation given the psychosocial risk profile.

- [To ensure a baby is safe] "You put in place a safety plan and you report them to the Department of Social Services and you get law enforcement...to investigate..." [COURTLAND 48:7-12]

Comments: This is correct in theory but was not implemented in reality. The "safety plan" was only nominal in nature. It was inadequate to effectively address the risk. In fact, law enforcement was not involved at all.

- [DSS has 45 days or more to complete an investigation.]

Comments: Therefore, in the interim, in an unsupervised home environment, the risk was still present and needed to be offset.

- [The Issue of suspected child abuse is based on] "not probability, possibility..." [COURTLAND 63:5-9]

Comments: The fact that there was no certainty in ruling in/out NAT was not a reason to exercise less caution in the discharge plan. The probability that it was abuse was not necessary to warrant caution, only the possibility.

- "The [medical] information was not able to be obtained, what we had available at the time [to determine if the injury was NAT]" [COURTLAND 64:5-6]

Comments: This is why the psychosocial data from the social worker becomes that much more important. In the absence of conclusive medical findings of abuse, the psychosocial data is key in determining the possible factors that give context to the medical findings with regard to potential risk of harm.

- The child's developmental milestone markers indicated that he "was not able to" roll, crawl, or walk. [COURTLAND 64:19-23]

Comments: In the absence of parental explanations for the injury, this lends even more credence to the possibility of NAT.

- "OK to discharge under supervision—will need to see in follow-up in 2 weeks." [COURTLAND, Exhibit 30]

Comments: The question is who needed the supervision, the child or the parents. Clearly, the available data indicated a need for supervision for the parents as much as for the child.

- "Please return in 2 weeks for repeat skeletal survey" [COURTLAND Exhibit 32]

Comments: The fact that a repeat skeletal survey was requested clearly indicates the continued suspicion that existed for the possibility of re-injury of the child. Despite this as being part of the discharge plan, the child was still returned to the unsupervised care of the parents who were still under suspicion of possible abuse.

- [Is the absence of a retinal hemorrhage, does that rule out that there is non-accidental trauma?] "No, it wouldn't...there would be, obviously, different ways to traumatize a child. [COOK 22:4]

Comments: Despite this negative medical finding, the psychosocial risk was still resent and misunderstood by the social worker.

Failure to thoroughly interview, probe, and explore the parents and other relevant collateral sources

Comments: Refer to above section for the information that may have been obtained had the family members noted been interviewed properly by the social worker(s). Such interviews should be conducted separately. The record reflects that the interviews that were conducted were done with others family members in the room.

Additional collateral sources that were available sources of information for the social worker to contact if/as necessary include: Daniel Lythgoe (paternal grandfather), Jennifer Lythgoe (paternal grandmother), Aaron Lythgoe (father's step-brother, age 12), and the "Thursday babysitter" (This person was never identified or interviewed)

Failure to request pertinent background records

Comments: There is no documentation that any medical, police, prior treatment, or other records were requested by the social workers. Such records are invaluable in conducting a comprehensive psychosocial assessment.

Failure to utilize standardized child abuse screening tools, inventories, and testing

Comments: The use of risk assessment instruments, inventories, and/or screening tools is generally considered to be useful in assessments for potential child abuse (e.g., Child Abuse Potential Inventory, Child Maltreatment Interview Schedule, The Parent Stress Index, etc.) A request to get a psychologist to administer these or any other tools to assess the risk potential for harm of the child should have been made. Such instruments are not used to determine who committed the abuse but instead to measure parental characteristics and family conditions that are believed to be predictors or precursors of potential child maltreatment or other harm to the child in order to determine the level of safety needed before the child is returned home.

COMMUNICATION

Failure of to fully comprehend the professional social work role and responsibilities within the context of the hospital's multi-disciplinary team and the inter-collaborative relationship with DSS

- "My responsibility as the medical social worker is to communicate information to DSS from the team and back to the medical team from DSS...["...all you are is just a messenger back and forth between the two of them?]" "...No, I can give my opinion to the doctors...and say that if there's anything in particular..."["Well, in this particular case, what insight did you give to the doctors?"] "I don't recall, off the top of my head..." [NEMWMARK 33:9; 55:10; 55:15]

Comments: Communicating with the team and outside agencies is only one facet of the social worker's role and responsibilities. The information that is communicated must include the social worker's psychosocial assessment, which is an integral part of the hospital team's information that must be gathered. The social work role is clinical, not just clerical. The professional social worker's perspective and contribution to the clinical picture is central to the hospital team's workup. Not only can the social worker give an opinion, this is what the social worker must do in ensuring that the hospital team has a complete understanding of the psychosocial dimensions of the patient's concerns and needs. In this case, the social worker did not contribute the social work perspective within the standard of care.

- "Part of the safety net and working on discharge, as far as the hospital social work piece, is to get DSS involved, because they can be involved in the home community, where we can't." [NEMWMARK 31:20]

Comments: Yes, part of the discharge "safety net" is to make a referral to DSS, but the other parts are to provide accurate information to the hospital team and other agencies based on a comprehensive psychosocial assessment, then offset that risk before the child is returned to the home/community, precisely because you don't know what might happen while DSS conducts its investigation.

- "I think that the medical team has a responsibility to do a workup on a child that comes in with an unexplained injury and part of that is calling DSS, working with them, making sure they have all the right information, doing everything we can to do a complete workup, as a way to help protect him [the child]." [NEMWMARK 47:6]

Comments: Yes, this is a more accurate understanding of the hospital's responsibility to ensure a safe discharge back to a safe environment, but the social worker did not make sure DSS "had all the right information" or "do everything we can to do a complete workup". To do so requires that the social worker contribution begins with a comprehensive psychosocial assessment.

- "I don't have any say as to where [the child] goes upon discharge, as a hospital employee...; I'm a liaison between the medical team and DSS...I share information on the clinical status and what's going on with the patient with DSS, who has the ultimate discharge plan put in place...I give them information. I don't control the final decision...; Disposition and discharge would be at the DSS discretion...[the state's responsibility?]...yeah, it's DSS...; In my experience...DSS tells us...when there's an open investigation, where the child is going to be discharged to...; Disposition has been determined by medical social worker and DSS—the way I could read that, back to me being a liaison, that I'm making sure that the team knows that DSS is involved in what they recommend." [NEWMARK 10:15, 10:25-11:1, 11:16, 11:24, 115:11, 115:17, 116:22]

Comments: The social worker clearly misunderstands her professional role in the multi-disciplinary team. She describes her role as primarily passing information onto DSS about the clinical status of the patient, yet diminishes her own responsibility in contributing to that information in terms of her own assessment of the patient's status. In effect, she describes her role as more clerical than clinical. In fact, as the social worker, the primary professional responsibilities include initial screening

and evaluation of patient and families, conducting comprehensive psychosocial assessments, counseling, crisis intervention, information and referral, educating hospital staff on patient psychosocial issues, promoting communication and collaboration among health care team members, and coordinating patient discharge and continuity of care planning, among other duties. The social worker is responsible for putting the medical data into a psychosocial context. While the physicians attempt to determine the etiology of the child's injuries based on the medical evidence, the medical social worker attempts to determine the etiology and intentionality of the injuries based on the psychosocial evidence. This is a key clinical and decisional responsibility, one which in the absence of conclusive medical data, becomes that much more critical.

- *"When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS....MSW Involved...Check with medical social worker about discharge...Extensive conversation with Dr. Morgan-Glenn [and] medical social worker regarding case...DSS to follow family with home visits, supervision...[Plan] cleared by medical social worker...[Per] DSS/social worker, OK to discharge with mom and dad. Will discharge home...Discharge home with parents with medical social work approval...Pending social work OK, patient OK to discharge" [COURTLAND Exhibits 2, 22, 23, 34, 35; COURTLAND 105-108]*

Comments: The attending pediatric physician and other medical professionals clearly rely on the input of the medical social worker with regard to the discharge planning process. Although there is a liaison component to the social work position, this is in regard to the responsibility to communicate relevant information with the team and outside agencies only. In arriving at a discharge disposition, the content of the social work psychosocial assessment is in large measure the key information that must be communicated to DSS in addition to the medical data as reported to the social worker by the physicians and other ancillary staff. The social work role is clearly much more than that of a liaison passing along information to DSS. The medical professionals within the hospital's multidisciplinary team distinctly recognize the decisional component of the social work role. In cases of suspected child abuse, the decision to discharge is the joint responsibility of both the social worker AND DSS, not either one independent of the other.

Failure to collaborate, consult, and follow-up appropriately with the hospital multi-disciplinary team, Department of Social Services (DSS), and/or others to effectively ascertain and communicate the nature of the high-risk for child abuse

Comments: There is no documentation anywhere in the record that the social worker communicated to any member of the hospital multi-disciplinary team, to DSS, or to law enforcement, any specific concerns regarding the family risk profile that would alert anyone among the inter-collaborative agencies involved, to the need for exercising caution in the discharge plan other than making a referral to DSS. This reflects the social workers lack of comprehension of the risk factors themselves. The referral to DSS was legally mandated based on the suspicion of abuse and does not reflect any degree of appropriate caution in protecting the child by recommending to anyone a more structured discharge plan and/or safety plan. In failing to appropriately assess, comprehend, and then communicate the inherent risk profile to the hospital multi-disciplinary team and DSS, the social worker set into motion a causal chain of misinformation that, passed from agency to agency, distorted and minimized the true nature of the high inherent risk for abuse and the need for more structured precautions.

- "I think the hospital fulfilled its duty in making the report to DSS and providing them with up-to-date- information." [NEWMARK 35:20]

Comments: The hospital's, and more specifically the social workers', duty was to conduct a competent psychosocial assessment, communicate accurately the potential risk of harm to the child, make a referral to DSS, then implement a safe discharge plan while DSS conducted its investigation. The ability to provide "up-to-date information" from the social work perspective assumes that a competent psychosocial risk assessment was conducted and communicated in addition to the medical findings. This, however, was not the case.

- [Regarding the role the hospital plays in DSS's investigation] "...we would certainly interview them and take into consideration any concerns that they have." [Do you look to them to help make your case decisions?] "Absolutely." [HINNANT 26:8]

Comments: The DSS supervisor highlights the fact that they depend on the input of the hospital staff to make their dispositions. The social work input is critical with regard to the psychosocial aspects of the case.

- "...If there had been something else that was of concern [as communicated by the hospital social worker], we may still have indicated our case...there were concerns that the parents were young and that they were immature and, maybe...concerns of lack of supervision." [HINNANT 64:5-12]

Comments: The concerns communicated to DSS indicate that the hospital's understanding of the risk to harm was grossly diminished, despite the numerous risk factors present and documented. The focus of "concerns" was around the parents' immaturity and lack of supervision of the child. This indicates that the hospital's understanding of the injuries (as communicated by the social worker) were skewed toward an interpretation and assumption of accidental trauma, when the risk of non-accidental trauma had not yet been ruled out. This tainted assessment of the facts significantly compromised an accurate communication of the facts to DSS.

- [We let the child go home because] "...the hospital wouldn't make a statement whether or not it was accidental or non-accidental...we had nothing...They said their concern was a lack of supervision...that someone wasn't watching the baby...somehow his head could've been bumped...they went on record saying it was either accidental trauma or non-accidental trauma. They weren't going to tell me...The hospital, they have implications in their case record that grandmother knew this was happening and did nothing...she had an idea...saw marks...I wish she had called us...They [the hospital] weren't giving us any indications that they had any real concerns, all those things that would indicate that the baby had been shaken, they didn't have any...See they [the hospital] should've been calling and making a report to us...had they any concerns...see, we could have looked at it a lot differently...that they [the parents] were acting suspicious and Kayla had called one day and made a remark that she was going to lose it, to come get the baby...so they didn't tell us any of this until afterwards...They're not giving us a whole lot. You know they won't make statements...And what happened is the social worker made the report on this and the doctor did not advise the social worker to make the report. They made that real clear to me when I called and spoke with them at the hospital...In this case they're not [giving us enough reason to remove the child] They don't have any suspicions." [AUDIO TRANSCRIPTS, CHRISTA DSS, 01/19/10]; [HINNANT 83:10-22]

Comments: The DSS supervisor clearly indicates the diminished sense of risk that was communicated by the hospital social worker. The social worker essentially reported only the medical findings to DSS, indicating that they could not rule out non-accidental trauma. None of the contextual

psychosocial risk factors were communicated. As a result, beyond simply reporting a lack of conclusive finding of abuse, the sense of risk was further diminished in conveying that the injury was more likely than not, accidental. Beyond not giving DSS a specific finding of abuse, the key is here is that the sense of risk was specifically minimized. This miscommunication of the potential risk was based on both the inadequate psychosocial assessment and the lack of comprehension of the significance of the available information by the hospital social worker.

- ["...(W)hat input does the hospital have into that (discharge) decision?" "....any concerns that they have had for us to address." [HILL 42:20]

Comments: DSS clearly relies on the hospital to communicate "any concerns" they may have with regard to their assessment of the child's needs.

- "Along with all that and what y'all had told me...I felt comfortable with it [not sending out a police investigator]. Maybe I shouldn't have...I didn't ever see that stuff that the grandfather or whoever it was said...they had seen all these mysterious bruises, and they even went so far as to photograph a bruise on the child at some point. See we weren't even made aware of any of that...If I can get all the information then it gives me a whole lot clearer [picture]...like what I'm reading here [about the subdural hematomas]...I'm going head-hunting!...But that one [the subdural hematoma] that went behind the...skull...you know that's not something they usually get by just falling, Lola....There's no consistency [in this case as to the parent's explanation of the injuries]...We definitely need to find out what the uncle's deal is, who he is, you know, all that good stuff...We're supposed to work as a team, we're not supposed to be pulling away from each other." [AUDIO TRANSCRIPTS, CHRISTA DSS, 01/19/10; LOLA DSS PART 1 & 2, 12/17/09]

Comments: After the child was re-injured in January, 2010, law enforcement (Lt. Miller) describes clearly how he was influenced by the diminished sense of risk and lack of information communicated to DSS by the hospital and then by DSS to him to the extent that the York County Sheriff's Office never initiated an investigation into the matter in December, 2009. Additionally, he articulates the suspicions he would have had regarding the case and how he would have explored these more fully than was already the case by both DSS and the hospital.

- "I think I would continue to work with community resources and make sure that there was going to be appropriate follow-up, if we were concerned that the follow-up wasn't going to happen. [NEWMARK 115:4]

Comments: One of the duties of the hospital social worker is to follow-up regarding the status of the collaborative referrals that are made in the community. The record does not indicate that any such follow-up was made by the social worker with DSS, the family, or any other agency. There was a follow-up skeletal survey scheduled outside of the hospital, but no social work follow-up is documented that considered the results of that second survey.

- "Yeah. It's like this one really fell through the cracks because nobody—PMC (Piedmont Medical Center) didn't call law enforcement on that one, and Levine's never called law enforcement. It's like, 'Holy crap.'" [AUDIO TRANSCRIPT, CHRISTA DSS PART 1 & 2, 12/17/09]

Comments: The option to refer a case to law enforcement is not the exclusive responsibility of DSS alone. Anyone can make such a referral. Given the nature of the risk profile, there was nothing to preclude the hospital social workers from contacting law enforcement in the interest of erring on the side of caution. Such a referral was never made.

INTERVENTION

Failure to develop an appropriate differential discharge plan that adequately utilized the numerous alternatives, options, and community-based resources available to ensure the child's safety

Comments: Because the social worker did not comprehend the inherent risk in a discharge to the home setting under the parents' supervision while DSS conducted its investigation over a period of weeks, the available alternatives for implementing a safe discharge plan were not considered. Some possible considerations include:

- Temporary foster care*
- Court order for ex parte removal of child*
- Live-in care*
- Initiate/coordinate law enforcement investigation*
- Appoint a Guardian Ad Litem*
- Delay discharge; keep in hospital until safety plan is established*
- Relative placement (assuming they have been evaluated and cleared)*
- Clear all visitation with DSS*
- Mother and father supervised at all times*
- Obtain a restraining order*

Examples of other appropriate discharge plans that could have been considered (based on the Jan, 2010, second hospital encounter):

- [On 01/11/10, as the DSS investigation began at the time of the second hospitalization, the following safety plan was written]: "Safety Plan: ...Kayla and Michael will have no unsupervised contact with Owen C. [REDACTED]. Owen C. [REDACTED] will not go home with Kayla and Michael. Levine's Children's Hospital will contact York County Department of Social Services when minor child to be released/discharged. Both parents will comply with safety plan—failure will result in court intervention. Case manager Hill will follow up with ALL parties and request records, etc...A copy of the safety plan was placed in Owen's file." [DSS00278]

Comments: This is exactly what should have been done at the time of the first hospitalization in December, 2009. If the risk was comprehended appropriately based on a competent and coordinated assessment by the social worker, this is all that had to be done at the time of discharge, to protect Owen while the appropriate investigation was further conducted by DSS and law enforcement.

- "Kayla Lythgoe will ensure that all immediate family including herself, grandparents, and step-grandparents, uncles, aunts, and cousins are to have supervised contact with Owen C. [REDACTED]. Kayla Lythgoe is responsible for ensuring compliance with the safety plan...A nursing assistant (sitter) was responsible to sit inside the room with the child and mother at all times...DSS will monitor safety plan through follow-up with Levine Children's Hospital. [The hospital] and or their designee is responsible for ensuring compliance with this safety plan." [DSS 00242-00243]

Comments: The known collateral sources should have been interviewed and such a plan put in place at the first hospitalization. Clearly, DSS looks to the hospital to assist in managing the discharge plan.

- January, 2010, second encounter: "Owen's DC is currently on hold secondary to DSS prohibiting him from going home with his mother with his grandmother present. His mother is currently working on clarifying what she needs to do to take Owen home with DSS and working on finding alternate housing so she does not have to stay with her mother." [DSS 0017]
- "Visitation plan continues to involve supervised visits only for Owen's maternal grandparents." [DSS0017]

- "Grandparents must legally supervise mother (and father) at all times."
[DSS0045]
- "Safety Plan: Kayla and Michael will have no unsupervised contact with Owen C. [REDACTED] Owen C. [REDACTED] will not go home with Kayla and Michael."
[DSS00147]

DOCUMENTATION

Failure to document effectively the nature of the assessment, communication, and interventions related to the high-risk for child abuse

- [The Suspected Child Abuse and Neglect form (SCAN) "wasn't completely filled...out because...that's a form that's used on admission. So all the information that is required to be put in that form had already been gathered before." [COURTLAND 55:7-13]

Comments: But the information to be gathered by the nurse [Lynn Meyers, RN] was not documented anywhere while the information that was documented by the hospital social worker was inadequate as well. The fact that the injury was not determined until after admission does not preclude each practitioner from conducting their own independent assessment before discharge. Each staff member has a responsibility to complete their own independent assessment during the hospitalization and to not "rubberstamp" the assessments of others.

IV. Conclusion

Although the defense contends that: "[t]he decision regarding the discharge of a child into the custody of his parents or to some other person or entity is a decision that must be made by the Department of Social Services (DSS), by law enforcement, or by the courts, and is not a decision which can be made by a hospital or physician [MOTION FOR SUMMARY JUDGMENT]", this is not the case.

As outlined in the hospital's (CMC) Child Abuse and Neglect Algorithm [NEWMARK Exhibit 2], in cases of suspected child abuse or neglect, discharge decisions are the joint responsibility of the hospital and DSS who work together to determine the appropriate disposition for the child. Specifically, the algorithm states: "When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS [NEWMARK Exhibit 2]."

DSS and law enforcement each depend upon the hospital's assessment of risk, which is based on a combination of both medical and psychosocial data. Within the context of the multi-disciplinary team model, the medical data is the responsibility of the hospital physicians, nurses, child maltreatment specialist, and other ancillary staff while the psychosocial data is the responsibility of the hospital social workers. The hospital discharge plan is the culmination of this two-pronged assessment of medical and psychosocial risk.

In December, 2009, although purportedly designed to offset the risk of the possibility of non-accidental trauma, both the hospital's discharge plan and DSS's safety plan clearly were based on the assumption that the child's injuries were more likely than not, accidental. This is evidenced by the fact that, while the parents were still under suspicion of having possibly abused the child, the child was placed back into their very care with instructions that they were to "...supervise Owen at all times and follow-up with all medical appointments...until [DSS] investigation ends [DEF PROD00166]. In essence, by allowing the child to return home in the control of the parents without the benefit of closely supervised, structured monitoring, the hospital (in conjunction with DSS) placed the child under the control of the two primary suspected potential perpetrators. This is analogous to appointing the fox to guard the henhouse.

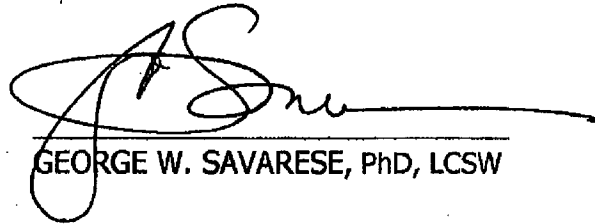
In effect, the hospital's discharge plan and DSS's safety plan instructed the parents to closely monitor the *child's* behavior, rather than setting up a plan in which the *parents'* behavior could be closely monitored and supervised, given the fact that they were still under continued suspicion for abuse. Given the inability of the hospital to rule out non-accidental trauma and the concomitant high-risk profile reflected in the psychosocial data available at the time, to instruct the parents to monitor the child without putting in place structured measures that would closely monitor and supervise the parents while DSS could complete it's

Investigation, was medically reckless. In such potentially high-risk scenarios, the standard of care is to err on the side of caution, especially in the face of numerous identified risk factors. In discharging the child under the supervision of his parents, by default, both the hospital and DSS instead erred on the side of assumption, that is, assuming the injuries were more likely than not, accidental.

In this manner, within the context of the interagency collaboration between the hospital, DSS, and law enforcement, in December, 2009, a causal chain of dangerously inaccurate information was communicated, beginning with the hospital social worker's deficient assessment of the psychosocial risk factors and her lack of comprehension of the resulting inherently high-risk of potential harm to the child. Acting in her liaison role with DSS, this lack of comprehension of the inherent risk, in combination with the non-conclusive medical data, was communicated to DSS, distorting and diminishing for DSS their overall understanding of the true nature of the inherent risk. This mitigated perception of risk then became the basis for the conjoint decision by both the hospital and DSS to discharge the child into the parents' care.

When DSS in turn communicated their distorted and diminished perception of the risk profile to law enforcement, it was once again misevaluated by law enforcement to be low therefore leading law enforcement to decide not to become involved in the case at all. But for the hospital social workers deficient assessment of the psychosocial risk factors and lack of comprehension of the resulting inherently high-risk of potential harm to the child, in addition to miscommunication referenced above, it is more likely than not this child would have been placed into custody with some other person than the custodial parents and the tragic situation in January 2010 would have been avoided.

Beginning with the hospital social workers whose primary role is to facilitate the safe transition from one level of care to another, they have a duty to conduct a competent psychosocial assessment, communicate accurately the results of that assessment to the relevant parties, refer the case to DSS, then implement a safe discharge plan that accurately takes the results of the assessment into account in order to prevent the risk of harm to the child. Although making a referral to DSS to investigate the case was a necessary step in discharging this duty, it was not sufficient. Providing DSS with an accurate appraisal of the potential risk of harm based on a competent psychosocial assessment and arranging for the child's safety while DSS completed its investigation was necessary. By breaching this duty, a causal chain of misunderstood and miscommunicated risk of potential harm ultimately led each organization involved in the continuum of care to not take the appropriate steps to put into place adequate safety measures necessary to protect the child, thereby resulting in the child's re-injury in January, 2010.


GEORGE W. SAVARESE, PhD, LCSW

Sworn to and signed before me
this 6 day of April, 2013



Notary Public



My Commission expires: 10/26/2016

Index for Savarese Exhibits

1. George W. Savarese, Ph.D., LCSW Curriculum Vitae
2. NASW Code of Ethics 2008
3. NASW Clinical Social Work in Social Work Practice 2005
4. NASW Social Work Practice in Health Care Settings 2005
5. NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
6. [NEWMARK EXHIBIT 10] Juveniles Suspected of Being Abused or Neglected PR 110.03
7. [COURTLAND EXHIBIT 14] Evaluation of Suspected Child Physical Abuse 2007
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9. York County [DSS 00143]
10. York County [DSS 00176]
11. York County [DSS 00179]
12. [SHER 0027-0028]
13. [DEF PROD 00219-0227] or [DSS-YS 0070-0078]
14. York County [DSS 00247]
15. York County [DSS 00236]
16. York County [DSS 00237] AND [DEF PROD 002916-17] or [SCDSS 0242-0243]
17. York County [DSS 00251]
18. York County [DSS 00248] actually [DSS 00247]
19. [SHER 000019-23]
20. York County [DSS 00171]
21. DEF PROD 00199] or [DSS-YS 0049]
22. York County [DSS 00271]
23. York County [DSS 00219] actually [DSS 00220]

- 24. [AUDIO TRANSCRIPTS, LOLA DSS PART 1 12/17/09] & PART 2 included
- 25. [COURTLAND, EXHIBIT 30] or CMC (12.05.09) 0039
- 26. [COURTLAND, EXHIBIT 32] or CMC (12.05.09) 003-4
- 27. [COOK 22:4]
- 28. [COURTLAND, EXHIBIT 2] actually [NEWMARK EXHIBIT 2]
- 29. [COURTLAND, EXHIBIT 22]
- 30. [COURTLAND, EXHIBIT 23]
- 31. [COURTLAND, EXHIBIT 34]
- 32. [COURTLAND, EXHIBIT 35]
- 33. [AUDIO TRANSCRIPTS CHRISTA DSS, 01/19/10]
- 34. York County [DSS 00278]
- 35. York County [DSS 00242-243]
- 36. York County [DSS 0017]
- 37. York County [DSS 0045]
- 38. York County [DSS 0147] Actually DEF PROD 00194 or DSS YS 0045
- 39. Excerpts from the Deposition of Laura NEWMARK
- 40. Excerpts from the Deposition of Cheryl COURTLANDT
- 41. Excerpts from the Deposition of Dirvondra HILL
- 42. Excerpts from the Deposition of Krista HINNANT
- 43. Excerpts from the Deposition of Rev. Larry WILLIAMS
- 44. Excerpts from the Deposition of Charlotte WILLIAMS
- 45. Excerpts from the Deposition of Kayla LYTHGROE

EXHIBIT

"1"

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EDUCATION

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Curaeta Care Systems, Park Ridge & Arlington Heights, Illinois

January, 1995 to present

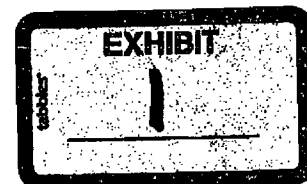
Executive Clinical Director. Founded and direct a private psychosocial services consultation organization which provides psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets; Direct the strategic planning, organizational and program development, research,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

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

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

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

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



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

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

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

ACADEMIC EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRAINING EXPERIENCE

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

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

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

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

CLINICAL EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESEARCH EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER EXPERIENCE

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

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

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

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

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

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

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

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

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

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

VOLUNTARY ACTIVITIES

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

PUBLICATIONS

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

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

MEMBERSHIPS/CERTIFICATIONS/LICENSES

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

EXHIBIT

"2"

**Code of Ethics in English Code of Ethics in Spanish**

**Code of Ethics
of the National Association of Social Workers**

Approved by the 1996 NASW Delegate Assembly and revised by the 2008 NASW Delegate Assembly

The 2008 NASW Delegate Assembly approved the following revisions to the NASW Code of Ethics:

1.05 Cultural Competence and Social Diversity

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

6.04 Social and Political Action

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

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Preamble

The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human ~~needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual wellbeing in a~~ social context and the wellbeing of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. The *Code* identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code*, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code's* values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and

standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code*, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this *Code*. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: Service

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: Social Justice

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: Dignity and Worth of the Person

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: Importance of Human Relationships

Ethical Principle: *Social workers recognize the central importance of human relationships.*

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the wellbeing of individuals, families, social groups, organizations, and communities.

Value: Integrity

Ethical Principle: *Social workers behave in a trustworthy manner.*

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: Competence

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO CLIENTS**1.01 Commitment to Clients**

Social workers' primary responsibility is to promote the wellbeing of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable,

social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker/client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to thirdparty payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

- (l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.
- (m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.
- (n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.
- (o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.
- (p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.
- (q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.
- (r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

- (a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.
- (b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

- (a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.
- (b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.
- (c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.
- (d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

1.16 Termination of Services

- (a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.
- (b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.
- (c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.
- (d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.
- (e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.
- (f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

- (a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.
- (b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.
- (c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the wellbeing of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

- (a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the wellbeing of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.
- (b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client wellbeing.

2.04 Disputes Involving Colleagues

- (a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.
- (b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

- (a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.
- (b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.
- (c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

- (a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.
- (b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.
- (c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships

- (a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.
- (b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues

- (a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.

(c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an

allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the *NASW Code of Ethics* and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the *NASW Code of Ethics*.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor/Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor/management disputes, job actions, or labor strikes should be guided by the profession's values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

- (a) Social workers should accept responsibility for employment only on the basis of existing competence or the intention to acquire the necessary competence.
- (b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.
- (c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

- (a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.
- (b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

- (a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.
- (b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.
- (c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations

- (a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.
- (b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

- (a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.
- (b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION**5.01 Integrity of the Profession**

- (a) Social workers should work toward the maintenance and promotion of high standards of practice.
- (b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.
- (c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.
- (d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.
- (e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

- (a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.
- (b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.
- (c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.
- (d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.
- (e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' wellbeing, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

- (f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.
- (g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.
- (h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.
- (i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.
- (j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.
- (k) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.
- (l) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.
- (m) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.
- (n) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.
- (o) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.
- (p) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

<http://www.socialworkers.org/pubs/code/code.asp>

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EXHIBIT

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NASW Standards for
Clinical

Social Work
in Social Work Practice

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Standards

for Clinical Social Work in Social Work Practice

Standard 1. Ethics and Values

Clinical social workers shall adhere to the values and ethics of the social work profession, utilizing the NASW *Codes of Ethics* as a guide to ethical decision making.

Standard 2. Specialized Practice Skills and Intervention

Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical intervention with individuals, families, and groups.

Standard 3. Referrals

Clinical social workers shall be knowledgeable about community services and make appropriate referrals, as needed.

Standard 4. Accessibility to Clients

Clinical social workers shall be accessible to clients during nonemergency and emergency situations.

Standard 5. Privacy and Confidentiality

Clinical social workers shall maintain adequate safeguards for the private nature of the treatment relationship.

Standard 6. Supervision and Consultation

Clinical social workers shall maintain access to professional supervision and/or consultation.

Standard 7. Professional Environment and Procedures

Clinical social workers shall maintain professional offices and procedures.

Standard 8. Documentation

Documentation of services provided to or on behalf of the client shall be recorded in the client's file or record of services.

Standard 9. Independent Practice

Clinical social workers shall have the right to establish an independent practice.

Standard 10. Cultural Competence

Clinical social workers shall demonstrate culturally competent service delivery in accordance with the *NASW Standards for Cultural Competence in Social Work Practice*.

Standard 11. Professional Development

Clinical social workers shall assume personal responsibility for their continued professional development in accordance with the *NASW Standards for Continuing Professional Education* and state requirements.

Standard 12. Technology

Clinical social workers shall have access to computer technology and the Internet, as the need to communicate via e-mail and to seek information on the Web for purposes of education, networking, and resources is essential for efficient and productive clinical practice.

Adopted by the NASW Board of Directors
June, 2005.

Introduction

Clinical social workers represent the largest group of behavioral health practitioners in the nation. They are often the first to diagnose and treat people with mental disorders and various emotional and behavioral disturbances. Clinical social workers are essential to a variety of client-centered settings, including community mental health centers, hospitals, substance use treatment and recovery programs, schools, primary health care centers, child welfare agencies, aging services, employee assistance programs, and private practice settings.

Clinical social work has a primary focus on the mental, emotional, and behavioral well-being of individuals, couples, families, and groups. It centers on a holistic approach to psychotherapy and the client's relationship to his or her environment. Clinical social work views the client's relationship with his or her environment as essential to treatment planning.

Clinical social work is a state-regulated professional practice. It is guided by state laws and regulations. In most instances, clinical social workers are required to have the following credentials:

- a master's degree from a social work program accredited by the Council on Social Work Education
- a minimum of two years or 3,000 hours of post-master's degree experience in a supervised clinical setting
- a clinical license in the state of practice.

Clinical social work is broadly based and addresses the needs of individuals, families, couples, and groups affected by life changes and challenges, including mental disorders and other behavioral disturbances. Clinical social workers seek to provide essential services in the environments, communities, and social systems that affect the lives of the people they serve.

Goals of the Standards

Clinical social workers are committed to the delivery of competent services to individuals, families, couples, and groups. Therefore, they shall recognize the client's role in his or her treatment planning and the client's right to have a knowledgeable, skilled practitioner who is guided by sound ethical practice.

These *Standards for Clinical Social Work Practice* set forth by the National Association of Social Workers (NASW) are intended to guide clinical social workers in all clinical settings. Specifically, the goals of the standards are to:

- maintain or improve the quality of services provided by clinical social workers
- establish professional expectations to assist social workers in monitoring and evaluating their clinical practice
- provide a framework for clinical social workers to assess responsible, professional behavior
- inform consumers, government regulatory bodies, and others about the professional standards for clinical social work practice.

The scope of clinical social work extends across many practice settings and populations. It is anticipated that these standards will reinforce and support current clinical practice in all settings, while affirming the value of clinical social work services as a discrete practice area.

Definitions

Client/Patient/Consumer

Social workers generally use the term “client” to refer to the individual, group, family, or community that seeks or is provided with professional services. The client is often seen as both the individual and the client system or those in the client’s environment. The term “consumer” is also used in settings that view the client as the consumer, that is, one capable of deciding what is best for her or himself and encourages self-advocacy and self-judgment in negotiating the social service and welfare system. The term “patient” is more commonly used by social workers employed in health care settings (Barker, 2003). The term patient may also be used for insurance reimbursement purposes in health and mental health settings.

Clinical Social Work

Clinical social work is the professional application of social work theory and methods to the diagnosis, treatment, and prevention of psychosocial dysfunction, disability, or impairment, including emotional, mental, and behavioral disorders (Barker, 2003).

Counseling

This is a procedure that is often used in clinical social work and other professions to guide individuals, families, couples, groups, and communities by such activities as delineating alternatives, helping to articulate goals, and providing needed information (Barker, 2003).

Person-in-Environment Perspective

This orientation views the client as part of an environmental system. It encompasses reciprocal relationships and other influences between an individual, relevant others, and the physical and social environment (Barker, 2003).

Psychodynamic

This word pertains to the cognitive, emotional, and volitional mental processes that consciously and unconsciously motivate an individual's behavior. These processes are the product of the interplay among a person's genetic and biological heritage, the sociocultural milieu, past and current realities, perceptual abilities and distortions, and his or her unique experiences and memories (Barker, 2003).

Psychotherapy

Psychotherapy is a specialized, formal interaction between a social worker or other mental health professional and a client (either individual, couple, family, or group) in which a therapeutic relationship is established to help resolve symptoms of mental disorder, psychosocial stress, relationship problems, and difficulties in coping in the social environment. Types of psychotherapy include,

but are not limited to family therapy, group therapy, cognitive-behavioral therapy, psychosocial therapy, and psychodrama (Barker, 2003).

Therapy

This is a systematic process designed to remedy, cure, or abate some disease, disability, or problem. This term is often used by social workers as a synonym for individual psychotherapy, conjoint therapy, couples therapy, psychosocial therapy, or group therapy (Barker, 2003).

Standards for Clinical Social Work in Social Work Practice

Standard 1. Ethics and Values

Clinical social workers shall adhere to the values and ethics of the social work profession, utilizing the NASW Code of Ethics as a guide to ethical decision making.

Interpretation

The social work mission is rooted in six core values: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 1999). All social workers have a responsibility to embrace these values as a service to clients, the profession, self, colleagues, and society. In delivering clinical social work services, the social worker's primary responsibility is to his or her client. Clinical social workers shall acknowledge the right of clients to receive competent psychosocial services and demonstrate a commitment to act on professional judgment and convictions,

which are informed by the *NASW Code of Ethics* (1999).

Clinical social workers shall be prepared for the challenges that encompass the assessment and treatment of people with mental disorders and behavioral or emotional disturbances.

This includes maintaining a commitment to the client while simultaneously demonstrating responsibility to the practice setting, society, and local, state, and federal policies and regulations governing the social worker's clinical practice. In the event that conflicts arise among competing interests, social workers are directed to the *NASW Code of Ethics* as one of the reference points for decision making. Services should only be provided in a setting in which the professional relationship can be maintained. Clinical social workers should adhere to the *NASW Code of Ethics* with regard to limits on private and/or dual relationships with clients.

Standard 2. Specialized Practice Skills and Interventions

Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical interventions with individuals, families, couples, and groups.

Interpretation

Drawing on knowledge of systems theory, person-in-environment orientation, psychodynamic theory, interpersonal dynamics, and family systems, clinical social workers shall be familiar with social, psychological, cultural, and health factors that influence the mental, emotional, and behavioral functioning of the client. They

shall have knowledge of theories of personality and behavior and be aware of sociocultural and environmental influences, as well as conditions that have an impact on the physical and emotional state of the client.

In addition to the above, clinical social workers shall have the ability to:

- establish and maintain a relationship of mutual respect, acceptance, and trust
- gather and interpret social, personal, environmental, and health information
- evaluate and treat problems within their scope of practice
- establish achievable treatment goals with the client
- facilitate cognitive, affective, and behavioral changes consistent with treatment goals
- evaluate the effectiveness of treatment services provided to the client
- identify appropriate resources and assessment instruments, as needed
- advocate for client services
- collaborate effectively with other social work or allied professionals, when appropriate.

When additional knowledge and skills are required to address clients' needs, the clinical social worker shall seek appropriate training, supervision, or consultation, or refer the client to a professional with the appropriate expertise. Clinical social workers shall limit the scope of their practice to those clients for whom they have the knowledge, skill, and resources to serve. They shall be accountable for all aspects of their professional judgment, behavior, and decisions.

Standard 3. Referrals

Clinical social workers shall be knowledgeable about community services and make appropriate referrals, as needed.

Interpretation

To ensure that clients receive optimal psychosocial services, it is sometimes beneficial to collaborate or coordinate services with appropriate community programs to strengthen or improve the continuity of care. Clinical social workers shall be knowledgeable about available community resources and advocate on behalf of the client for appropriate services. The clinical social worker shall maintain collaborative contacts with social work or other related professionals and make appropriate referrals, as needed. The clinical social worker shall not share information about the client without the client's informed consent or as otherwise indicated in Standard 5.

Standard 4. Accessibility to Clients

Clinical social workers shall be accessible to their clients.

Interpretation

Clinical social workers shall be available to provide clinical services to clients during regularly scheduled appointment times or sessions. In addition, the clinical social worker shall develop emergency plans or be available to the client for emergency coverage during vacations, holidays, illnesses, and at other times when the office may be closed. Arrangements or plans and procedures for emergency coverage shall be made in partnership with competent mental health

professionals or reputable institutions and should be discussed with the client at the initial face-to-face interview.

In addition, the office setting should be accessible and/or have helping devices for persons with disabilities, or office limitations should be discussed prior to scheduling appointments.

Standard 5. Privacy and Confidentiality
Clinical social workers shall maintain adequate safeguards for the private nature of the treatment relationship.

Interpretation:

Confidentiality is a basic principle of social work intervention. It ensures the client that what is shared with the social worker will remain confidential, unless there is an ethical or legal exception. All information related to or obtained from the client by the clinical social worker shall be viewed as private and confidential. Clinical social workers shall be familiar and comply with local, state, and federal mandates governing privacy and confidentiality, such as the federal Health Insurance Portability and Accountability Act (HIPAA) requirements and state medical records laws.

Information obtained by the social worker from or about the client shall be viewed as private and confidential, unless the client gives informed consent for the social worker to release or discuss the information with another party. There may be other exceptions to confidentiality as required by law or professional ethics. Social workers should be

familiar with national, state, and local exceptions to confidentiality, such as mandates to report when the client is a danger to self or others and for reporting child or elder abuse and neglect. The clinical social worker shall advise the client of confidentiality limitations and requirements at the beginning of treatment.

Professional judgment in the use of confidential information shall be based on best practice, as well as legal, and ethical considerations.

Standard 6. Supervision and Consultation

Clinical social workers shall maintain access to professional supervision and/or consultation.

Interpretation

Clinical social workers should ensure that professional social work supervision is available to them in a clinical setting for the first five years of their professional experience (NASW, 2004). If clinical social worker supervisors are not available or accessible, case consultation may be obtained from qualified professionals of other related disciplines. Those clinical social workers with more than five years of clinical experience shall use consultation on an as-needed, self-determined basis. Clinical social workers shall adhere to state and federal statutes and regulations regarding supervision and consultation in their states of practice.

When appropriate, clinical social workers should offer their expertise to individuals, groups, and organizations, as well as offer training and mentoring opportunities to

beginning social workers or those making the transition into clinical social work. In addition, experienced clinical social workers who are able should offer supervision to social workers seeking state licensure for clinical social work practice.

Standard 7. Professional Environment and Procedures

Clinical social workers shall maintain professional offices and procedures.

Interpretation

Agencies providing clinical social work services and clinical social workers in private or independent practice shall develop and implement written policies that describe their office procedures, such as the client's rights, including the right to privacy and confidentiality; notices and authorizations; procedures for release of information, fee agreements; procedures for payment; cancellation policy; and coverage of services during emergency situations or when the clinical social worker is not available. These policies shall be made available to and reviewed with each client at the beginning of treatment. Clinical social workers should maintain appropriate liability insurance and have a current working knowledge of risk management issues.

In addition to the above, the treatment setting shall be properly maintained to ensure a reasonable degree of comfort, privacy, and security for the social worker and the client.

Standard 8. Documentation

Documentation of services provided to, or on behalf of, the client shall be recorded in the client's file or record of services.

Interpretation

Clinical social workers must document all services rendered to clients and keep the records in a secure location, maintaining them as private and confidential records. Documentation must reflect an accurate account of services. Progress notes, reports, and summaries of services shall be regularly recorded in the client's file and be consistent with all applicable local, state, and federal statutory, regulatory, or policy requirements. Records must meet current federal provisions regarding privacy, security, and electronic transactions standards and code sets.

Standard 9. Independent Practice

Clinical social workers shall have the right to establish an independent practice.

Interpretation:

Clinical social workers may establish an independent solo or group practice. When doing so, they shall ensure that all services, including diagnostic and treatment planning, meet professional standards. When clinical social workers employ staff, they, as employers, bear responsibility for the competency of all services provided; maintaining clinical and ethical standards; and upholding all local, state, and federal regulations.

To avoid conflicts of interest, clinical social workers who are both employed by agencies

and have independent practices shall not refer agency clients to themselves without prior agreement with the agency and consent of the client. In addition, the clinical social worker shall have offered alternative options to the client, such as transferring the client to another treatment provider within the agency or terminating services.

Clinical social workers in private or independent practice may bill third-party payers or their clients for services rendered. Clients shall be provided with all invoices and receipts in a timely manner. When a client can no longer afford services—or a third-party payer or an agency terminates services—an alternative mutually agreed upon with the client may be instituted, which could include, for example, a referral, termination of services, a sliding scale, or pro bono services. If services continue, consideration must be given to any applicable federal or state laws and regulations as well as insurance or managed care contracts that may limit the type of continuing care.

When a client chooses to terminate treatment, the clinical social worker will offer to aid the client in exploring barriers to treatment and re-examine the treatment plan to help the client reach termination constructively. When appropriate, the clinical social worker shall refer the client to another qualified treatment provider.

Standard 10. Cultural Competence

Clinical social workers shall demonstrate culturally competent service delivery in accordance with the *NASW Standards for Cultural Competence in Social Work Practice*.

Interpretation

The increasingly diverse population seeking psychosocial services requires that clinical social workers raise their awareness and appreciation of cultural differences. Clinical social workers shall have, and continue to develop, specialized knowledge and understanding about history, traditions, values, and family systems as they relate to clinical practice with individuals, families, and groups. Clinical social workers shall be knowledgeable about and demonstrate practice skills consistent with the *NASW Standards for Cultural Competence in Social Work Practice* (2001). In addition, clinical social workers need to be knowledgeable about the deleterious effects of racism, sexism, ageism, heterosexism or homophobia, anti-Semitism, ethnocentrism, classism, and disability-based discrimination on clients' behavior, mental and emotional well-being, and course of treatment. Clinical social workers must also recognize racial, ethnic, and cultural differences that may be interpreted as barriers to treatment and develop skills to ameliorate such barriers.

Standard 11. Professional Development

Clinical social workers shall assume personal responsibility for their continued professional development in accordance with the *NASW Standards for Continuing Professional Education* and state requirements.

Interpretation

To practice effectively, clinical social workers must remain knowledgeable about emerging theories and interventions, best practice models in the social work profession, and changes in policies and regulatory reforms

such as the HIPAA regulations. Clinical social workers shall seek to enhance their skills and understanding by staying abreast of research to ensure that their practice reflects the most current knowledge. Clinical social workers should also seek continuing education about risk management and professional liability issues.

Numerous opportunities in professional development are available through NASW and other professional organizations or institutions, coalitions, and service agencies at local, state, and national levels. Clinical social workers should regularly participate in and contribute to professional conferences and training activities and contribute to and promote professional publications.

Standard 12. Technology

Clinical social workers shall have access to computer technology and the Internet, as the need to communicate via e-mail and to seek information on the Web for purposes of education, networking, and resources is essential for efficient and productive clinical practice.

Interpretation

Clinical social workers are increasingly using the Web, computers, and other electronic technology to improve the quality of services for clients, to communicate with other professionals, and for documentation purposes. Clinical social workers should keep abreast of electronic changes that may affect practice. Technology may be integrated into clinical practice; however, appropriate safeguards for client privacy shall be used.

Clinical social workers should engage in ongoing training in technology applications relevant to clinical social work practice including assessment and treatment, research, policy, education, and resource tracking and development.

Free information on the Standards is located on the NASW Web site: www.socialworkers.org.

Purchase full document from NASW Press at 1.800.227.3590.

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EXHIBIT

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 **N A S W**
National Association of Social Workers



NASW Standards for

Social Work Practice

in Health Care Settings

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Introduction

The constant growth, demands, and changes in health care have had a serious impact on the viability and need for social workers in all areas and settings of health care. More than 15 percent of the population or 45 million people in the United States were without health insurance coverage during 2003 (U.S. Census Bureau, 2004). Access to timely, comprehensive, and equitable health care for individuals in the United States varies considerably, with significant percentages of many populations having only limited access to health care. The growth in medical technology has offered hope and improved quality of life to many people; yet, the advances in technology have also raised health care costs and introduced social, legal, and ethical dilemmas for individuals, families, and health care providers. These psychosocial implications of health care are what social workers are trained to address.

Currently, health care social workers provide services across the continuum of care and in various settings. Social workers are present in public health, acute, and chronic care settings providing a range of services including health education, crisis intervention, supportive counseling, and case management. In response to critical incidents that are both global and national, health care social workers are increasingly trained to provide interventions to prepare for and respond to traumatic events and disasters.

The health care system in the United States is complex and multidisciplinary in nature, and

may include a network of services such as diagnosis, treatment, rehabilitation, health maintenance, and prevention provided to individuals of all ages and with a range of needs. Multiple sources of financing, ranging from Medicare and Medicaid to private insurance, provide further challenges. Many consumers lack health insurance or have inadequate coverage, which causes financial stress on consumers and providers.

Professional social workers are well equipped to practice in the health care field, because of their broad perspective on the range of physical, emotional, and environmental factors that have an effect on the well-being of individuals and communities. These standards are developed to meet the needs of social workers in multiple health care practice settings and to help the public understand the role of the professional social worker. The National Association of Social Workers (NASW) recognizes that standards alone cannot improve the quality of practice unless they are disseminated and implemented at the practice level. Client satisfaction and improved quality of care result when social workers and administrators recognize and use these standards.

Background

Social workers have been involved in the health care field since the turn of the 20th century. The profession's earliest concerns were with making health care services available to the poor and with improving social conditions that bred infectious diseases such as

tuberculosis. As the social work role expanded, social workers joined other health professions in the delivery of high quality services. Today, social workers can be found in every component of the health care system. In 1977, NASW published *Standards for Hospital Social Services*. In 1980, the *Standards for Social Work in Health Care Settings* were developed and replaced the hospital standards. Between 1981 and 1982, the NASW Board of Directors approved the new standards, and three subsections were developed, approved, and added to the health care standards. The subsections included the *Standards for Social Work in Developmental Disabilities*, *Standards for Social Work in End-Stage Renal Disease Treatment Settings*, and *Standards for Social Work in Public Health Settings*.

In the early 1980s, a capitated system for payment of Medicare services in acute health care settings, known as diagnostic-related groups (DRGs), was initiated by the federal government. This initiative, generically known as managed care, fundamentally altered health care financing for both public and private health care systems. Managed care focused on reducing the length of stays in acute care facilities, and this led to a fundamental shift in the role of social workers in acute health care. Social workers became more focused on planning for an individual's transition to home or to another level of care. Social work services disappeared entirely from some health care settings due, in part, to a lack of data demonstrating the efficacy of social work services and loss of funding for those services. Yet, in other settings, social workers have prospered, gaining recognition through the